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MONTANA LEGISLATIVE HISTORY

Chapter S 90 19 95

Bill H _____ S 223 Original bill & history ✓ C

H. Committee on Human Services & Aging			S. Committee on Public Health Welfare & Safety		
Hearing Date(s)	Mar 06	✓ C	Hearing Date(s)	Feb 15	✓ C
	Mar 15	✓ C			C
		C			C
		C			C
Date Out	Mar 16	✓ C		Feb 15	✓ C

Did this bill originate in an interim committee? ____Yes ____No

Committee _____ Report _____

Conference Committee Apr 09

Free Conference Committee Apr 12

SB 223 INTRODUCED BY KEATING, ET AL.

RELATE TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

1/23	INTRODUCED		
1/23	FIRST READING		
1/23	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
1/24	FISCAL NOTE REQUESTED		
1/30	FISCAL NOTE RECEIVED		
1/31	FISCAL NOTE PRINTED		
2/15	HEARING		
2/15	COMMITTEE REPORT—BILL PASSED		
2/16	2ND READING PASSED	50	0
2/17	3RD READING PASSED	50	0
	TRANSMITTED TO HOUSE		
2/20	FIRST READING		
2/20	REFERRED TO HUMAN SERVICES & AGING		
3/06	HEARING		
3/16	COMMITTEE REPORT—BILL CONCURRED		
3/29	2ND READING CONCURRED AS AMENDED	80	20
3/30	3RD READING CONCURRED	75	22
	RETURNED TO SENATE WITH AMENDMENTS		
4/05	2ND READING AMENDMENTS NOT CONCURRED	50	0
4/06	CONFERENCE COMMITTEE APPOINTED		
4/07	CONFERENCE COMMITTEE REPORT NO. 1		
4/08	2ND READING CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	48	0
4/10	3RD READING CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	49	0
	HOUSE		
4/06	CONFERENCE COMMITTEE APPOINTED		
4/08	CONFERENCE COMMITTEE REPORT NO. 1		
4/12	2ND READING CONFERENCE COMMITTEE REPORT NO. 1 REJECTED	53	43
4/12	CONFERENCE COMMITTEE DISSOLVED		
	SENATE		
4/12	FREE CONFERENCE COMMITTEE APPOINTED		
4/12	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/13	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	50	0
4/13	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	50	0
	HOUSE		
4/12	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/13	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	54	45
4/13	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	71	28
4/18	SIGNED BY PRESIDENT		
4/18	SIGNED BY SPEAKER		
4/18	TRANSMITTED TO GOVERNOR		
5/10	SIGNED BY GOVERNOR CHAPTER NUMBER 590 EFFECTIVE DATE: 10/01/95		

SENATE BILL NO. 223

INTRODUCED BY Keating Walt Jonson

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Swysgood Evans et al Tom Nelson

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM; PROVIDING FOR THE AWARD, MANAGEMENT, PAYMENT, AND AVAILABILITY OF THOSE SERVICES; PROVIDING FOR EXCEPTIONS TO LAWS GOVERNING INSURANCE CONTRACTS AND HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING FOR ELIGIBILITY DETERMINATIONS AND LIMITATIONS; REVISING THE PROCEDURES FOR VOLUNTARY ADMISSION TO THE MONTANA STATE HOSPITAL; AMENDING SECTIONS 33-1-102, 33-31-202, 33-31-301, 53-1-401, 53-1-402, 53-1-413, 53-2-603, 53-6-131, 53-6-132, 53-21-111, AND 53-21-206, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-102, MCA, is amended to read:

"**33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs.** (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of those organizations are authorized by chapter 31.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, parts 21 and 23, and related sections.

(6) This code does not apply to the functions performed by a managed care contractor providing mental health services under the Montana medicaid program as established in Title 53, chapter 6.

~~(6)~~(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

~~(7)~~(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

~~(8)~~(9) (a) This code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) This code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program."

Section 2. Section 33-31-202, MCA, is amended to read:

"**33-31-202. Issuance of certificate of authority.** (1) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after ~~he receives~~ receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may ~~in his discretion~~ consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection ~~therewith~~ with the services;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with 33-31-216; and

(vi) any additional information ~~as~~ that the commissioner may reasonably require.

(d) The enrollees ~~will~~ must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may ~~in his discretion~~ deny a certificate of authority only if ~~he complies with~~ the requirements of 33-31-404 are complied with."

Section 3. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence

of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area;.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and

nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is ~~hereby~~ amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, ~~his~~ dependents, or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of ~~his~~ membership in the class or classes eligible for coverage under the policy or because ~~his~~ the employer discontinues ~~his~~ the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months

preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)

through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, ~~he~~ the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for ~~his~~ the disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receipt of a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any relevant information ~~he considers~~ considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 4. Section 53-1-401, MCA, is amended to read:

"**53-1-401. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "All-inclusive rate" means a fixed charge that is computed on a daily basis or on the basis of another time period for inpatients, that is computed on a per visit basis for outpatients, and that is applicable uniformly to each patient without regard to the extent of the services required by the patient and without regard to a distinction between physician services and hospital services.

~~(1)~~ (2) "Ancillary charge" means the expense of providing identifiable, direct, resident services, including but not limited to:

(a) physicians' services;

(b) x-ray and laboratory services;

(c) dental services;

(d) speech-language pathology and audiology services;

(e) occupational and physical therapy;

(f) medical supplies;

(g) prescribed drugs; and

(h) specialized medical equipment.

~~(2)~~ (3) "Care" means the care, treatment, support, maintenance, and other services rendered by the department to a resident.

~~(3)~~ (4) "Department" means the department of corrections and human services provided for in Title 2, chapter 15, part 23.

~~(4)~~ (5) "Financially responsible person" means a spouse of a resident, the natural or adoptive

parents of a resident under 18 years of age, or a guardian or conservator to the extent of the guardian's or conservator's responsibility for the financial affairs of the person who is a resident under applicable Montana law establishing the duties and limitations of guardianships or conservatorships.

~~(5)~~ (6) "Full-time equivalent resident load" means the total daily resident count for the fiscal year divided by the number of days in the year.

~~(6)~~ (7) "Long-term resident" means a resident in an institution listed in 53-1-402 for a continuous period in excess of 120 days. ~~No~~ The absence of a resident from the institution due to a temporary or trial visit may not be counted as interrupting the accrual of the 120 days required to attain the status of a long-term resident.

~~(7)~~ (8) "Per diem" means the gross daily budgeted cost of operating an institution or an individual unit of an institution (including certain contracted medical services, depreciation, and associated department costs but excluding the cost of educational programs, federal grants, ancillary charges, and costs not directly identified with patient care) divided by the full-time equivalent resident load.

~~(8)~~ (9) "Resident" means any person who is receiving care from or who is a resident of an institution listed in 53-1-402.

~~(9)~~ (10) "Third-party resource" means but is not limited to applicable medicare, medicaid, and personal health care benefits."

Section 5. Section 53-1-402, MCA, is amended to read:

"**53-1-402. Residents subject to per diem and ancillary charges.** (1) The department shall assess and collect per diem and ancillary charges for the care of residents in the following institutions:

(a) Montana state hospital;

(b) Montana developmental center;

(c) Montana veterans' home;

(d) eastern Montana veterans' home;

(e) Montana center for the aged;

(f) Eastmont human services center.

(2) This section does not apply to the eastern Montana veterans' home if the department contracts with a private vendor to operate the facility as provided for in 10-2-416.

(3) This section does not apply to residents of the Montana state hospital or to the Montana center

for the aged to the extent that either of these institutions assesses and collects charges through an all-inclusive rate rather than per diem and ancillary charges."

Section 6. Section 53-1-413, MCA, is amended to read:

"**53-1-413. Deposit of payments.** (1) Except as provided in 90-7-220 and subsection (2) of this section, the department shall deposit payments of per diem and ancillary charges in the state treasury to the credit of the general fund.

(2) Payments from the Montana veterans' home ~~shall~~ must be deposited in the federal special revenue fund for the benefit of the home, and payments from the Montana state hospital alcohol program ~~shall~~ must be deposited to an alcohol state special revenue account.

(3) Payments from a managed care contractor, provided for in 53-6-116, for services provided by the Montana state hospital and the Montana center for the aged must be deposited in the state special revenue fund, subject to appropriation by the legislature for the benefit of those institutions."

Section 7. Section 53-2-603, MCA, is amended to read:

"**53-2-603. Award of public assistance determined after investigation.** (1) Upon completion of an investigation, the county board shall determine whether the applicant is eligible for public assistance under the provisions of this title, the type and amount of public assistance ~~he~~ the applicant ~~shall~~ must receive, and the date upon which ~~such~~ the public assistance ~~shall~~ must begin. This subsection does not apply to any form of public assistance managed by a managed care contractor, as provided in 53-6-116, when a determination of eligibility is made by the managed care contractor.

(2) The department, if necessary to conform with the United States Social Security Act, may issue rules to the county welfare departments requiring the use of the declaration method, in ~~such~~ a form ~~as~~ that the department may prescribe, for the purpose of determining eligibility, regardless of any other investigative provisions under this title, and for all types of assistance. These rules may include any additional investigations the department may require."

Section 8. Section 53-6-131, MCA, is amended to read:

"**53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of social and rehabilitation services, in

its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. 1381, et seq.) or aid to families with dependent children under Title IV of the federal Social Security Act (42 U.S.C. 601, et seq.).

(b) The person would be eligible for assistance under a program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under one of the programs in subsection (1)(a).

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan for aid to families with dependent children, other than with respect to school attendance.

(e) The person is under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a hard-to-place child.

(f) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(e) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the department the amount by which the person's income exceeds the medically needy income level specified for federally aided categories of assistance; and

(B) has resources that are within the resource standards of the federal supplemental security income program.

(g) The person is a qualified pregnant woman or child as defined in 42 U.S.C. 1396d(n).

(2) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program.

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the

department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

(a) has income that does not exceed income standards as may be required by the federal Social Security Act; and

(b) has resources that do not exceed standards the department determines reasonable for purposes of the program.

(4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

(5) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.

(6) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.

(7) A person described in subsection (6) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(8) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees to be charged recipients for services. The fees may vary according to family income."

Section 9. Section 53-6-132, MCA, is amended to read:

"**53-6-132. Application for assistance -- exception.** (1) ~~Application~~ Except as provided in

subsection (2), application for assistance under this part ~~shall~~ must be made to the office of the county department in the county in which the person is residing. The application ~~shall~~ must be presented in the manner and on the form prescribed by the department of social and rehabilitation services. All individuals wishing to apply ~~shall~~ have the opportunity to do so.

(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the county department to determine eligibility for medicaid managed care services."

Section 10. Section 53-21-111, MCA, is amended to read:

"**53-21-111. Voluntary admission.** (1) Nothing in this part may be construed ~~in any way as limiting~~ to limit the right of any person to make voluntary application for admission at any time to any mental health facility or professional person. An application for admission to a mental health facility ~~shall~~ must be in writing on a form prescribed by the facility and approved by the department. ~~It~~ An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily ~~admitting himself~~ admitted. A statement of the rights of the person voluntarily applying for admission, as set out in this part, including the right to release, ~~shall~~ must be furnished to the patient within 12 hours.

(2) Any applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person ~~must~~ shall then obtain confirmation from ~~a community mental health center~~ the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from ~~a community mental health center~~ the department or the department's designee as required in this section.

(3) An application for voluntary admission ~~shall~~ must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past ~~his~~ the applicant's written request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility ~~must~~ shall notify all applicants of ~~such~~ the rules and post ~~such~~ the rules as provided in 53-21-168.

(4) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility."

Section 11. Section 53-21-206, MCA, is amended to read:

"**53-21-206. Availability of services.** (1) The services of the department and of the incorporated regional mental health centers are available without discrimination on the basis of race, color, creed, religion, or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964.

(2) Services available to individuals unable to pay for the services may be limited by the department based upon availability of funding."

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0223, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill relating to managed care mental health services provided under the Montana Medicaid program.

ASSUMPTIONS:

1. Eligibility for mental health benefits for children and adults under the managed care system will be expanded to those with annual gross incomes less than 200% of poverty.
2. A federal waiver will be granted to Montana by the federal Health Care Financing Administration (HCFA) to implement this program. Upon approval of the waiver, Medicaid federal funds will become available for reimbursement for services provided at Montana State Hospital (MSH) and the Center for the Aged (CFA).
3. The waiver request will be approved in time for the program to be implemented July 1, 1996.
4. Medicaid services are funded at the FMAP matching rate of 30.26% general fund and 69.74% federal funds in FY96 and 31.00% general fund and 69.00% federal funds in FY97.
5. The Executive Budget present law base contains anticipated savings of $622,789 (where $188,456 is general fund and $434,333 is federal funds) during FY96 and $701,628 (where $217,393 is general fund and $484,235 is federal funds) during FY97 due to implementation of managed care mental health. However, delays in getting approval of the waiver and getting the program started will delay implementation to FY97. Regardless of whether this legislation passes or fails, the savings for FY96 will need to be added back into the Medicaid primary care budget, since these savings will not be realized. If this proposed legislation does not pass, then the savings for FY97 will also need to be added back into the Medicaid primary care budget, since those savings will not be realized either.
6. An Executive Budget new proposal regarding Medicaid primary care reflects an additional anticipated savings of $2,100,000 general fund during FY97. This is an impact in addition to the Executive Budget present law base discussed in assumption 5 above, and is shown below as a reduction in expenditures in FY97.
7. The Department of Corrections and Human Services (DCHS) assumes the managed care contractor would guarantee a specific number of beds which would be used at MSH and at CFA, and be reimbursed through the managed care mental health contract during the next five years. The number of beds is still to be negotiated.
8. In FY97, DCHS would transfer $36,950,019 general fund and $1,023,073 in federal funds to SRS which would contract for and reimburse mental health services on behalf of DCHS.
9. In the event that this legislation is passed and the waiver is received, DCHS will need $20,773,720 in state special revenue spending authority in FY97 in order to receive payments from the managed care contractor.

(continued)

Dave Lewis 1-30-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Keating

TOM KEATING, PRIMARY SPONSOR DATE

10. The expenditures shown below would be included in HB2 as a line item with language included that states in the event the waiver is delayed or not approved, the savings reflected in FY97 will be adjusted or added back to the primary care budget, since the mechanism for generating the savings will not exist. (Please see assumptions 5, 6 and 9 above.)

FISCAL IMPACT:

	FY96 Difference	FY97 Difference
Expenditures:		
Medicaid Primary Care Benefits	622,789	(2,801,628)
Funding:		
General Fund	188,456	(2,317,393)
Federal Fund	434,333	(484,235)
Total Funds	622,789	(2,801,628)
Net Impact:		
General Fund Cost/(Savings)	188,456	(2,317,393)

BILL NO	REFERRED	HEARING	OTHER CONSIDERATION DATES	EXECUTIVE ACTION/DATE/VOTE	REREFERRED	DATE READ
SB0124	CRISMORE, WILLIAM	MODIFY SANITARY INSPECTIONS TO BE DISCRETIONARY PUBLIC HEALTH INSPECTIONS				
	1/13	2/01		DO PASS 2/1 VOTE:		2/02
SB0134	KLAMPE, TERRY	REQUIRE HEALTH CARE PROVIDER NOTIFICATION OF FINANCIAL INTEREST IN REFERRALS				
	1/13	2/08		PASS AS AMENDED 2/8 VOTE:		2/08
SB0146	ECK, DOROTHY	UNIFORM HEALTH-CARE DECISIONS ACT				
	1/16	2/01		TABLED ON 02/01 VOTE:		
SB0157	WATERMAN, MIGNON	CHILD BICYCLE SAFETY ACT				
	1/16	1/23		TABLED ON 01/30 VOTE:		
SB0158	WATERMAN, MIGNON	LONG-TERM CARE REFORM				
	1/16	2/13		DO PASS 2/15 VOTE:		2/15
SB0168	CHRISTIAENS, CHRIS	REQUIRING USE OF A COMMUNITY SERVICES SCREENER AND FINANCIAL NEEDS REPORTS				
	1/17	2/06		TABLED ON 02/08 VOTE:		
SB0171	FRANKLIN, EVE	LICENSE PHYSICAL THERAPY ASSISTANTS				
	1/17	1/30		DO PASS 1/30 VOTE:		1/31
SB0194	BAER, LARRY	REVISE HEALTH CARE AUTHORITY LAW; REPEAL SMALL EMPLOYER HEALTH INSURANCE				
	1/18	2/10		PASS AS AMENDED 2/17 VOTE:		2/18
SB0209	SWYSGOOD, CHUCK	REFORM WELFARE; AUTHORIZE SRS FAIM PROGRAM AND FOOD STAMP PROGRAM				
	1/20	2/03		PASS AS AMENDED 2/6 VOTE:		2/07
SB0217	DOHERTY, STEVE	CLARIFY INDIAN CHILD WELFARE SPECIALIST QUALIFICATIONS				
	1/21	2/06		DO PASS 2/8 VOTE:		2/08
SB0223	KEATING, TOM	EXPAND COVERAGE OF MEDICAID MANAGED CARE MENTAL HEALTH				
	1/23	2/15		DO PASS 2/15 VOTE:		2/15
SB0226	KEATING, TOM	REQUIRE LICENSE TO PRACTICE OR REPRESENT TO BE A PROFESSIONAL COUNSELOR				
	1/23	2/17		PASS AS AMENDED 2/17 VOTE:		2/18

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By **CHAIRMAN JIM BURNETT**, on February 15, 1995, at 12:02 PM

ROLL CALL

Members Present:
Sen. James H. "Jim" Burnett, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. Larry L. Baer (R)
Sen. Sharon Estrada (R)
Sen. Arnie A. Mohl (R)
Sen. Mike Sprague (R)
Sen. Dorothy Eck (D)
Sen. Eve Franklin (D)
Sen. Terry Klampe (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Karolyn Simpson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: SB 240, SB 223, SB 310
Executive Action: SB 240, SB 310, SB 223, SB 248, SB 158, SB 236, SB 339

{Tape: 1; Side: 1}

HEARING ON SB 240

Opening Statement by Sponsor:

SENATOR FRED VAN VALKENBURG, SD 32, Missoula, said SB 240 is a proposal to amend the statutes for licensure of physicians in Montana to create a restrictive license to practice medicine for physicians who have been foreign-trained, but have attained a level of recognition greater than most in Montana. The reason for this legislation is, St. Patrick Hospital in Missoula in particular, has an opportunity to recruit a physician, Dr. Carlos Duran, who has a tremendous international reputation, to work with the Heart Institute. For about 5 years, St. Patrick Hospital in Missoula has had a Heart Institute that is gaining

Larry White said he thought the answer is yes, but could be better answered by someone on the board. The restricted license doesn't relieve the individual from having to meet all the other ethical or hospital standards that would apply to others.

Patricia England, Attorney, Board of Medical Examiners, said that was a concern of the Board, that unqualified individuals from inadequate schools should not be able to slip through under this restrictive license. Dr. Duran is not going through the usual gamut of qualifications, it's a different set of criteria. They want to make sure the hurdles are high enough, which is the reason for the current research and publication requirement within the last 2 years, not 10-15 years ago. There is language that specifically refers to section 37-3-323, which is the professional conduct, disciplinary statute. She referred to SB 240, page 2, line 23, and said, this bill specifically states the person is going to be held to the same standards of care and professional conduct as other licensed physicians in Montana.

Closing by Sponsor:

SENATOR VAN VALKENBURG said people, such as Dr. Duran, will find Montana an attractive place to live, and we have a tremendous opportunity to have access to care that someone like Dr. Duran can provide, and can attract research dollars into the state, which is an economic tool.

EXECUTIVE ACTION ON SB 240

Motion/Vote: SENATOR FRANKLIN moved SB 240 DO PASS. The motion CARRIED UNANIMOUSLY.

HEARING ON SB 223

Opening Statement by Sponsor:

SENATOR TOM KEATING, SD 5, Billings, said SB 223, dealing with mental health services, is at the request of the Department of Social and Rehabilitation Services for managed care for mental health. Many mental health recipients said they are capable of holding down a job, but don't work because they would lose their Medicaid benefits. To qualify for Medicaid, mental health clients have to be on SSI and get a subsistence of less than $500 a month, on which to live. If they are below those eligibility levels, they qualify for Medicaid, which provides their medication that stabilizes them in order to function. Their medication prescriptions cost between $600.00 and $1300.00 per month. It's difficult for them to earn that kind of money. If they earn more than $900.00 per month, they lose their SSI and Medicaid. The providers of mental health treatment say that work is an essential part of the recovery program, along with the counselling and medications.

SB 223 raises the eligibility level to 200% of the poverty level to still qualify for Medicaid. These people will come into a program for screening, evaluation, and their eligibility will give them a share of Medicaid to get appropriate treatment, and go to work, doing some co-pay, while regaining their health. When they can be treated, then returned to society as a productive people, they can take care of themselves, pay taxes, and stop the generational cycle of mental health and emotional disturbances. This Medicaid program is limited to mental health services. It will not address physical Medicaid. The case management will be operated by a private company, which is expert in designing and evaluating, but all of the mental health services will be provided by Montana providers. The program is designed for cost-containment with appropriate care, with the objective of successful treatment.

Proponents' Testimony:

SENATOR CHRIS CHRISTIAENS, SD 23, Cascade Co., said passage of SB 223 will allow for the management and complex care of mental health patients. It will also improve the quality of care and outcomes, and will give the flexibility to respond to local in-community situations. It has as the focus, a medical delivery system giving parity, and manage benefits through utilization-based, assuring quality-based continuum of care at the most appropriate level of care. Managed care will allow better management of limited resources and will serve clients in the least restrictive manner.

Peter Blouke, Director, Department of Social and Rehabilitation Services, spoke briefly in support of SB 223 from his written testimony. **EXHIBIT 2.**

SENATOR MIGNON WATERMAN, SD 26, Helena, said she served on the task force that put together this proposal and this bill gives the opportunity to pull together the whole mental health system. It has been recognized that the mental health system is fractured within the state budgeting process. Combined meetings were held with the Institutions Subcommittee and Human Service Subcommittee, because in the past there were two different committees looking at the mental health budget. This will allow a unified system that can serve youth and adults, as well as individuals at the state hospital.

Hugh Black, Ph.D., Psychologist in Helena, member of the board Montana Psychological Association, and representing Montana Coalition of Mental Health Providers, spoke in support of SB 223. The state Medicaid Division has worked with an advisory group, composed of individuals concerned about mental health, to establish a proposal that provides cost containment, while preserving the standards of effective care and safeguards for some of Montana's most vulnerable citizens. He said appropriate and timely mental health care lowers overall medical costs. The

present situation does not encourage people to lift themselves out of poverty if there are urgent mental health needs.

Frank Lane, Executive Director, Eastern Montana Mental Health Center, said this bill will begin to take care of the mentally ill in the state. He urged passage of SB 223.

Kathy McGowan, representing the Montana Council of Mental Health Centers, said she had been a member of the task force and SB 223 represents the best of what can happen with a federal-state partnership, working together to contain costs and have a better system. The 200% of poverty is scary, but in this state most of these people are already being served with 100% general fund dollars.

Donna Hale, Licensed Clinical Social Worker and self-employed as a psycho-therapist, representing the Montana Chapter of the National Association of Social Workers and private practitioners in the field of mental health, said a bill for managed care of Medicaid mental health introduced last year, at the request of the Department of SRS, during the special Legislative session, greatly concerned most of the people in private practice of mental health. Then SRS formed a committee, which included consumers, family members, public and private sector providers, and all of the departments that would be involved, to forge a program on which they all agree. They strongly support the program and urge passage of SB 223.

Bob Ross, Director of Region 3 Mental Health Center in Billings, spoke in support of SB 223. He said that it is unusual to see agreement among those in the mental health arena, but there is agreement on SB 223. Even though this bill will allow flexibility, quick access to treatment, uniform treatment standards, bring in all the other providers so there would be better access to care, mental health care costs will not be reduced in the State of Montana if there are no work opportunities made available. Region 3 has a contract with vocational education, out of SRS, to provide a transitional employment program, and a training employment program for their consumers who are seriously mentally ill. People who enroll in this program need to have some stability in their illness, and it gives them an opportunity to work and earn wages. Statistics show that mentally ill people who are placed in employment positions do not use mental health services as much. If employment is not made an important part of mental health care, the cost of mental health care will not be reduced.

Dan Anderson, Administrator of the Mental Health Division, Department of Corrections and Human Services, said they support SB 223.

Pat Melby, representing Rimrock Foundation and speaking on behalf of the Chemical Dependency Programs of Montana, said while the people served by chemical dependency programs are not included in

SB 223, the organization still supports this bill. The majority of people who are chemically dependent are often times diagnosed with a mental illness. The treatment of both diseases must be closely coordinated and done as a whole, rather than disjointed. They hope, in the future, the Legislature will include chemical dependency in the managed care system.

Bill Kennedy, Yellowstone County Commissioner and Chairman of the Mental Health Board in Billings, urged support of SB 223.

Patrick Pope, Executive Director of the Meriweather Lewis Institute and a member of the Medicaid Managed Care advisory group, said he has a mental illness, which is managed by medications, peer support and therapy. He said, under Managed Care, the Montana mental health system can operate as an efficient system that helps those with mental illness. The current mental health system is a care-taking system and once a person is in the system there is little chance of getting out. Under Managed Care, services that make sense can be implemented, not just those that take. Managed Care offers real hope to mental health consumers. He said that if the mentally ill can work and pay taxes, the cost in services is less.

David Hemion, representing the Montana Mental Health Association, read his written testimony in support of SB 223. **EXHIBIT 3.**

Paul Meyer, Executive Director, Region 5 Mental Health Center, which serves the seven counties of Western Montana, spoke in support of SB 223. He said it will give an opportunity to re-think the public mental health dollars being spent by the state, and create a better system for individuals. He referred to the concern that had been raised about the 200% of poverty level. Now, people have a choice of maintaining Medicaid eligibility and their treatment services or getting a job. This program, with a graduated fee schedule, would have people cost-sharing over 100% of the poverty level, up to 200% where they're paying full cost of treatment, but there would no longer be a choice between a job and Medicaid benefits.

Marty Onishuk, Vice President of the Montana Alliance for the mentally ill, spoke in support of SB 223. She said it's a chance for a continuum of care under one entity. Now the community mental health centers, which are federally mandated and partially federally funded, are responsible for community-based services, the state hospital completely funded by the state General Fund, and there are people bouncing between the two systems. There has been a problem tracking family members and friends of family members, as they leave the state hospital and move to another part of the state because different agencies in different parts of the state have different programs and treatment. SB 223 would make a similar system throughout the state. The fee for service, now in existence for Medicaid, only pays for certain services, and as family members, there are other services they would like to have that are not provided now. They were able to get case

management included as a service, and would like to see housing included also.

Mary Alice Cook, representing Advocates for Montana's Children, said they support SB 223, but with the reservations about children, to which David Hemion referred in his written testimony.

Andree Larose, staff attorney for the Montana Advocacy Program, made a brief statement from her written testimony in support of SB 223. **EXHIBIT 4.**

{Tape: 1; Side: 2; Comments: lost first 30 seconds at beginning of tape}

Candy Wimmer, Montana Board of Crime Control, and representing the Justice Council, said they support Managed Care for kids because many of the youth who enter the criminal justice system have mental illness or emotional disturbances. Those youth are sent to places where money is available for treatment, which does not mean that treatment was the most appropriate to meet their needs. The Managed Care system will allow a broader array of services to meet the actual needs of youth and be able to serve a broader group of youth.

Opponents' Testimony: None

Questions From Committee Members and Responses:

SENATOR FRANKLIN asked about the waiver process.

Peter Blouke said all of the waivers have been submitted to the Federal Government, they have raised some concerns, but it is not final. The State Hospital will be included as part of the Managed Care system, but not a Medicaid reimbursable basis.

SENATOR FRANKLIN asked about the contract bidding process.

Peter Blouke deferred to **Mary Dalton, SRS.** She said the Federal Government has said, until they improve the waiver, the State cannot let the RSP. SRS is in the process of developing the RSP, letting that out for public content in March.

SENATOR BENEDICT referred to the fiscal note, asking about the savings. He said, there's an expenditure in the first year of the biennium and a savings in the second year of the biennium, but, whether or not the bill passes, the savings of $2.1 million would go back into the Medicaid primary care budget, and it appears there would be no true savings to the General Fund, but just reallocated into the Medicaid primary care budget.

Peter Blouke replied, if it says that, it's an error, because those funds have been reduced from the Primary Care budget.

SENATOR BENEDICT referred to Assumption 5 of the Fiscal Note, and read the last 2 sentences. **EXHIBIT 5.**

Peter Blouke said they had anticipated beginning Managed Care in FY 96, so there was $2.1 million in FY 96 identified as savings, then $2.1 in FY 97 as savings. Because the waiver process has taken longer than anticipated, there will be no savings in FY 96, consequently, the $2.1 million that was taken out of the budget has to go back in.

SENATOR ECK asked about the children's program, the safety of the funding, and preventing its going to adult care.

Peter Blouke said that has been a concern, but they don't want to tie up any particular funding source. The department should be allowed flexibility to distribute the funds as deemed appropriate by the advisory group. They are going to be bringing up the children's program in FY 97 to the Legislature.

SENATOR ECK asked about the advisory council.

Peter Blouke said the advisory council would be continued because it is helpful in giving the Department ideas for structuring.

SENATOR FRANKLIN asked how private practitioners are responding to RFT and will these practitioners be able to compete.

Donna Hale said the private practitioners were initially opposed having this process regionallized, and requested language be included in the RFP that anyone licensed in Montana be eligible as a provider to patients of the program, giving some freedom of choice to consumers for choosing their providers. One difficulty private practitioners have faced is, currently the system has not allowed for outcome measures, and they know there are abuses of the system and inefficiencies they haven't been able to correct.

Closing by Sponsor:

SENATOR KEATING said this touches a lot of people. The mental health community throughout the State, from every level of provider and client are constantly networking, and meetings held frequently. This area has a huge impact on the State budget, costs needs to be controlled, and services delivered. The goal is for effective services with reduced spending. He asked the Committee to favorably consider SB 223.

HEARING ON SB 310

Opening Statement by Sponsor:

SENATOR JUDY JACOBSON, SD 18, Butte, said SB 310 changes the time for the prescription of Class II drugs from 72 hours to 34 days, and allow both the Nutritionist and Physician Assistant full

EXECUTIVE ACTION ON SB 223

Motion: **SENATOR BENEDICT moved SB 223 DO PASS.**

Discussion: **SENATOR FRANKLIN** said she thinks they need to be careful about funding for children's services.

SENATOR BENEDICT said he favors the bill but has some reservations about the fiscal note. It looks like there's an expenditure in the first year and a savings in the second year, but ends up to be a savings even though it goes to Medicaid primary care because SRS had already taken it out of their budget. He said after 1997, this will be a good vehicle for money savings.

SENATOR ECK said it needs to be recognized, that over the years, growth has been contained, but never thought about the possibility of saving money.

Vote: **The Do Pass motion for SB 223 CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 194

Discussion: **SENATOR BAER** said there are some amendments.

Susan Fox said the second longer amendment has incorporated the first amendment.

Motion: **SENATOR BAER moved the AMENDMENTS to SB 194 DO PASS.**

Susan Fox explained the amendments to SB 194, saying most of the amendments deal with section 1. Right now it's a discretionary program with the Department of Health. SB 285 would transfer the administration of the state health plan to the Health Care Authority on July 1, 1996. When drafting this bill, there was an inadvertent error changing it to a mandatory program. It was intended to take the provision that gave it to the Health Care Authority and say don't transfer it to the Health Care Authority. Because the bill is inaccurate from what **SENATOR BAER** intended, section 1 will be taken out. She referred to section 1, lines 17-21, Chapter 606 Laws of 1993, saying it will get rid of the transfer function. The amendments in 1, 2, and 3 will leave it as is, a discretionary program in the Department of Health, and no FTE's will have to be added.

The other amendment (numbers 4, 5, and 6) deals with section 11, page 10, amended to "the Advisory may health insured management plans." This enables them to utilize the plan already submitted prior to January 1, 1994, and puts no more requirements on the insurers.

Amendment 7 cleans up the classification instructions, taking the section out of law.

MONTANA SENATE
1995 LEGISLATURE
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL DATE 2/15/95

NAME	PRESENT	ABSENT	EXCUSED
LARRY BAER	X		
SHARON ESTRADA	X		
ARNIE MOHL	X		
MIKE SPRAUGE	X		
DOROTHY ECK	X		
EVE FRANKLIN	X		
TERRY KLAMPE	X		
STEVE BENEDICT, VICE CHAIRMAN	X		
JIM BURNETT, CHAIRMAN	X		

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SENATE STANDING COMMITTEE REPORT

February 15, 1995

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration SB 223 (first reading copy -- white), respectfully report that SB 223 do pass.

Signed: Jim Burnett
Senator Jim Burnett, Chair

Amd. Coord.
Sec. of Senate

391641SC.SRF

SENATE HEALTH & WELFARE
EXHIBIT NO 2
DATE 2/15/95
BILL NO SB 223

TESTIMONY OF THE DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES
BEFORE THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

(Re SB 223 - An Act Relating to
Medicaid Managed Care Mental Health Services)

In conjunction with the Departments of Corrections and Human Services and Family Services, and with the cooperation of the Office of Public Instruction and the Commissioner of Insurance, the Department of Social and Rehabilitation Services has been doing extensive planning for a system of managed care for all publicly funded mental health services in Montana. That planning was required by HB33 as passed by the 1993 Special Session. The bill before you will accomplish a number of changes in law that are necessary to implement the program we have designed.

Working with the Department of Corrections and Human Services we determined that to have an effective and comprehensive managed care program it was necessary to include all state-funded mental health services under the new system. It then became necessary to find a way to include those people whose mental health services are currently paid, in full or in part, by the state general fund. To do so we have proposed to expand Medicaid eligibility, for mental health services only, to Montanans with an income of up to two hundred percent (200%) of the Federal Poverty Level. For a family of four that would equate currently to an annual income of $29,600. Approximately forty percent (40%) of Montana families fall within this standard. We are proposing a graduated fee schedule under which persons qualifying for this expanded eligibility would pay a portion of their mental health treatment costs. This bill will authorize the Medicaid program to accomplish this.

Another important component of our proposed system is to have the managed care contractor perform eligibility determinations for people qualifying under this expanded category. SRS has insufficient personnel available for what will be a large workload expansion. This bill will allow us to have eligibility determinations for mental health managed care performed by an entity other than the county welfare offices.

After consultation with the Commissioner of Insurance, we have determined that some adjustments are also needed in the insurance law to implement our managed care program. First, we are asking that the contractor under the Medicaid mental health managed care program be exempt from requirements that they be licensed as an insurance company. We believe that few of the national managed care companies which have expressed an interest in bidding on our program would be able or willing to meet the extensive requirements for becoming an insurer in Montana. Neither we nor the Commissioner believe it is necessary. We will have extensive financial reporting and solvency requirements in our managed care

contract, and the Commissioner's staff has agreed to assist us in evaluating the financial abilities of the bidders and in establishing solvency requirements.

The insurance laws must also be changed in order for us to require that the managed care contractor be responsible for arranging for all Medicaid mental health services. Currently health maintenance organizations are required by law to provide behavioral health services. This bill will remove those services from the package required of HMOs serving Medicaid clients. Then we can enroll Medicaid recipients in HMOs for physical health care without weakening the effectiveness and comprehensiveness of our mental health initiative. This exemption will avoid the necessity of creating an entire new set of regulations for this unique situation.

This bill also addresses some minor changes needed in the mental health laws to permit the managed care program to work effectively. It authorizes Montana State Hospital and the Center for the Aged to receive payments from the managed care contractor and to use those payments for the operation of the institutions. When the funds normally allocated to them by the legislature are included in the capitation payment to the managed care contractor, this will allow the two institutions to be paid as providers under the managed care system.

Finally, the bill makes two additional minor changes in the mental health statutes. One allows the Department of Corrections and Human Services to designate an entity other than the community mental health centers to screen voluntary admissions to Montana State Hospital. This gives the department additional flexibility in anticipation of a changing array of providers under managed care. Another allows the department to limit services if sufficient funding is unavailable.

This diverse amalgam of changes to existing laws is needed not to authorize a mental health managed care program, which was done by the 1993 Special Session, but to allow the program to go forward as designed and as efficiently as possible. It is important to note that Montana will need to receive waivers to a number of federal regulations in order to implement this program. If this does not come about, all of these changes will have no effect on the operation of the state's mental health system.

On behalf of the Department of Social and Rehabilitation Services, I urge you to pass SB 223. Thank you for the opportunity to speak to this important bill.

Peter S. Blouke, PhD
Director
Department of Social and Rehabilitation Services

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 2/15/95
BILL NO. SB 223

TESTIMONY OF DAVID HEMION
PUBLIC POLICY COORDINATOR
MENTAL HEALTH ASSOCIATION OF MONTANA
SB 223 - MENTAL HEALTH MANAGED CARE
FEBRUARY 15, 1995

The Mental Health Association of Montana represents some 1,200 mental health consumers, providers, family members and others interested in achieving victory over mental illness. On behalf of MHA, here are its positions and thoughts on mental health managed care.

1. MHA SUPPORTS A PRE-PAID MANAGED MENTAL HEALTH PLAN, COMBINING STATE AND MEDICAID FUNDS.

MHA believes that managed care offers a solution to both cost-containment and quality service delivery. The American Academy of Actuaries has concluded that managed care for mental health services can save between 30 to 40 percent over unmanaged fee-for service or minimally managed delivery systems. AAA conducted studies of the Health Security Act of 1993 and estimated that costs for treatment of mental illnesses and substance abuse would drop: from $240 to $305 per person annually for unmanaged care to $45 to $165 per person under managed care.

In actual experience, large corporate health plans track these estimates. Bell South reduced its spending for mental health benefits by 30 percent over three years. Alcan Aluminum reduced its annual mental health per capita claims from $170 to $ $70 over two years.

Public sector experience is similar. A Brandeis University study of the mental health Medicaid managed care system for the state of Massachusetts, implemented in 1991, showed a 22 percent reduction over anticipated costs and actual savings of $23 million.

We need to temper our expectations about Montana's projected system. Please remember that savings for Medicaid-eligible clients may not be as great as general populations, as those included are in varying conditions of poverty, which places them at higher risk for mental illnesses and health problems.

The Brandeis study also found that quality of service did not suffer, as indicated by a decline in recidivism rates of about 20 percent. Access also improved with increases in numbers of users of 22 percent.

Imagine that. A decrease in costs, increase in clients served with quality maintained or improved.

2.MHA SUPPORTS RETAINING SAVINGS WITHIN THE SYSTEM

We believe that Montana needs to retain funds saved by managed care, at leaset through initial years, to address service gaps, improving prevention, early intervention and access, especially for difficult to serve populations, such as those in remote areas.

3. MHA SUPPORTS INCLUDING SERVICES PROVIDED BY MONTANA STATE HOSPITAL IN MANAGED CARE.

MHA expects all patients admitted by MSH, except forensic patients, to be included. We anticipate that managed care will increase treatment of patients at the community level, decrease admissions to MSH and discharge patients sooner and to an improved after care continuum.

4. MHA CONTINUES TO EXPRESS CONCERN REGARDING THE COMBINING OF PUBLIC FUNDS TARGETED TO CHILDREN'S SERVICES WITH FUNDS FOR ADULT TREATMENT.

Our concerns are two-fold. First, Montana is working hard to overcome a past lack of coordination of children's services, primarily through the MRM program. We are concerned that the gains MRM has made may be rolled back, unless funding for children's services is somehow protected. We support the recommendation of Dan Anderson of the Department of Corrections and Human Services to earmark funding for children's services to prevent shifts to adult services.

Our second concern is that actions to date in this Legislative session indicate that inadequate funding will be provided for children's services. The 50 percent cut in the MRM program and denial of funding for the Community Impact program are tragic. We urge the legislature to restore funding to levels recommended by the Governor for both these programs.

This concern also extends to adult services. Funding for community level crisis intervention and housing is the only way to prevent costlier hospitalization. The funding requested for these services must be restored by the Legislature.

To ignore this request invites an avoidable disaster for the mental health of the children of Montana. It also assures the failure of managed care, as we doubt any contractor would be willing to take on the task of managing an underfunded system.

5. MHA SUPPORTS EXPANDING COVERAGE TO 200 PERCENT OF POVERTY.

This is in the self-interest of all Montana tax payers, as it allows a shift from general fund-supported services to federal funding. It also provides a preventative measure by assuring early intervention and treatment of mental illnesses for working Montanans who are uninsured or underinsured.

EXHIBIT 3
DATE 2-15-95
SB 223

4.MHA APPRECIATES THE INITIATIVE OF THE DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES IN PURSUING MANAGED CARE AND ITS RESPONSIVENESS TO QUESTIONS AND CONCERNS RAISED BY MHA AND OTHERS.

SRS has been prompt in responding to detailed and extensive questions provided by MHA. We appreciate the opportunity to be represented on the Advisory Council by Joan-Nell Mcfadden, chair of MHA's Children's Committee and Candy Butler, MHA president-elect. We look forward to the opportunity to review and comment upon the RFP and to be actively involved in monitoring the implementation of managed care.

8. WE SUPPORT SB 223 AND URGE YOUR PASSAGE.

EXHIBIT NO. 4
DATE 2/15/95
BILL NO SB223

MONTANA ADVOCACY PROGRAM, Inc.
316 North Park, Room 211
P.O. Box 1680
Helena, Montana 59624

(406)444-3889
1-800-245-4743
(VOICE - TDD)
Fax #: (406)444-0261

February 15, 1995

Senator Jim Burnett
Senate Public Health Committee
State Capitol
Helena, Montana 59620

Re: SB 223

Mr. Chair and Members of the Committee:

For the record, my name is Andree Larose and I am a staff attorney for the Montana Advocacy Program. Montana Advocacy Program is a non-profit organization which advocates the rights of individuals with disabilities. We are here to testify in support of SB 223.

1. We support the mental health managed care proposal because we believe it will provide a more coordinated system for ensuring that persons with mental illness receive appropriate care in the least restrictive environment. So often the types of services a person receives are dictated more by funding sources and what is available, rather than what is appropriate to meet the person's needs. Historically, mental health services at a community level have been severely underfunded, yet those very services could prevent unnecessary hospitalization.

2. We also anticipate that managed care would emphasize early treatment and intervention. So often people with mental illness do not receive necessary treatment at earlier stages and the problems associated with the mental illness escalate, so that the person ends up receiving "high end" treatment at the greatest cost to taxpayers.

3. We are concerned about a potential conflict of interest if the managed care organization (MCO) provides some direct mental health services.

4. We are happy to see that SRS recognizes that for treatment to be effective, it is essential that individuals and families participate in developing and implementing treatment plans. We urge SRS to include in the Request for Proposal a process which ensures that the input of individual clients and families has weight and is not an exercise in futility.

5. We urge SRS to include in the RFP appropriate mechanisms to deal with disagreements between a consumer and the MCO. The risk of utilizing a managed care system is that services may be compromised in order to ensure a profit to the MCO. We believe that with adequate safeguards this risk can be minimized.

6. For these reasons, we request that the Montana Advocacy Program, as well as representatives from other consumer and advocacy groups, be active participants in the development of the RFP, not just by giving input but by being included in a more formal capacity.

7. We also request that advocacy and consumer groups be included in a formal capacity in the regular quality reviews of the MCO.

8. Finally, we urge the immediate inclusion of the Montana State Hospital in the managed care proposal. SRS itself recognizes that if MSH is not included and is funded separately with guaranteed general fund dollars, it will become a dumping grounds for people with mental illness. Already there are many patients at MSH who do not need that high cost level of service, but who are there only because there are inadequate community based services. To delay inclusion of MSH in managed care is to continue the waste of spending 18 million dollars per year in operating costs and to continue to insulate MSH from the realities of a competitive system in which more appropriate services are funded and unnecessary services are not funded. Those clients who do require inpatient treatment may still be placed at MSH under the managed care proposal; it's only those clients who do not belong there in the first place who will be affected.

Thank you for your time.

Sincerely,

Andree Larose
Staff Attorney

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2/15/95
BILL NO. SB 223

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0223, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill relating to managed care mental health services provided under the Montana Medicaid program.

ASSUMPTIONS:
1. Eligibility for mental health benefits for children and adults under the managed care system will be expanded to those with annual gross incomes less than 200% of poverty.
2. A federal waiver will be granted to Montana by the federal Health Care Financing Administration (HCFA) to implement this program. Upon approval of the waiver, Medicaid federal funds will become available for reimbursement for services provided at Montana State Hospital (MSH) and the Center for the Aged (CFA).
3. The waiver request will be approved in time for the program to be implemented July 1, 1996.
4. Medicaid services are funded at the FMAP matching rate of 30.26% general fund and 69.74% federal funds in FY96 and 31.00% general fund and 69.00% federal funds in FY97.
5. The Executive Budget present law base contains anticipated savings of $622,789 (where $188,456 is general fund and $434,333 is federal funds) during FY96 and $701,628 (where $217,393 is general fund and $484,235 is federal funds) during FY97 due to implementation of managed care mental health. However, delays in getting approval of the waiver and getting the program started will delay implementation to FY97. Regardless of whether this legislation passes or fails, the savings for FY96 will need to be added back into the Medicaid primary care budget, since these savings will not be realized. If this proposed legislation does not pass, then the savings for FY97 will also need to be added back into the Medicaid primary care budget, since those savings will not be realized either.
6. An Executive Budget new proposal regarding Medicaid primary care reflects an additional anticipated savings of $2,100,000 general fund during FY97. This is an impact in addition to the Executive Budget present law base discussed in assumption 5 above, and is shown below as a reduction in expenditures in FY97.
7. The Department of Corrections and Human Services (DCHS) assumes the managed care contractor would guarantee a specific number of beds which would be used at MSH and at CFA, and be reimbursed through the managed care mental health contract during the next five years. The number of beds is still to be negotiated.
8. In FY97, DCHS would transfer $36,950,019 general fund and $1,023,073 in federal funds to SRS which would contract for and reimburse mental health services on behalf of DCHS.
9. In the event that this legislation is passed and the waiver is received, DCHS will need $20,773,720 in state special revenue spending authority in FY97 in order to receive payments from the managed care contractor.

(continued)

Dave Lewis 1-30-95
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Keating
TOM KEATING, PRIMARY SPONSOR DATE

10. The expenditures shown below would be included in HB2 as a line item with language included that states in the event the waiver is delayed or not approved, the savings reflected in FY97 will be adjusted or added back to the primary care budget, since the mechanism for generating the savings will not exist. (Please see assumptions 5, 6 and 9 above.)

FISCAL IMPACT:

	FY96 Difference	FY97 Difference
Expenditures:		
Medicaid Primary Care Benefits	622,789	(2,801,628)
Funding:		
General Fund	188,456	(2,317,393)
Federal Fund	434,333	(484,235)
Total Funds	622,789	(2,801,628)
Net Impact:		
General Fund Cost/(Savings)	188,456	(2,317,393)

DATE 2/15/95

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 240, SB 223
SB 310

< ■ > PLEASE PRINT < ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
DONNA HALE	MT Chp NASW	223	✓	
Bob Torres	MT Chp NASW	223	✓	
Randy Poulsen	SRS	223	✓	
Frank R Lane	E. MMHC	223	✓	
Larry White	St. Patrick Hosp.	240	✓	
JIM OURY	"	240		
Gary Elliott	R.S. ImmunoChem	240	✓	
Carole Erickson	St. Patrick Hosp.	240.	✓	
BOB RAM	MENTAL HEALTH	223	✓	
PAUL MEYER	MHC - Region 5	223	✓	
KATHY McGOWAN	MCMHC	223	✓	
Jennifer Krueger	MONTANA ACADEMY OF PHYSICIAN ASSTS	310	✓	
RANDY SPEAR	BOWE	310/240	✓	
RANDY SPEAR	MAPA	310	✓	

David Henion Mental Health Assoc. 223 ✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: 2-15-95

_____

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Oppose
Ben Lindeman PAC		240 310	X	
Jerome Loendorf	Mt. Pet Assn	310	Sec 2 ✓	Sec
" "	" " "	240	✓	
Mary Alice Cook	Adv. for MTs Children	223	✓	
Pat Melby	Rimrock Foundation	223	✓	
Hugh M. Black PhD	Montana Coalition of Mental Health Providers	223	✓	
Gloria Hermanson	MT Psych. Assn	223	✓	
Claudy Wimmer	MBCC	223	✓	
Dan Anderson	DCHS	223	✓	
Bill Kennedy	Yellowstone Co	223	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETAR

BILL NO	REFERRED	HEARING	OTHER CONSIDERATION DATES	EXECUTIVE ACTION/DATE/VOTE	REREFERRED	DATE READ
SB0055	ECK, DOROTHY 1/30	2/03	CLARIFY DFS PAYMENT OF PROTECTIVE SERVICES ADMINISTRATIVE COSTS	CONCUR 03/01 VOTE: 10-0	APPROPRIATIONS	3/02
SB0084	CHRISTIAENS, CHRIS 2/03	3/01	ELIMINATE SERVICES AT MONTANA CHEMICAL DEPENDENCY CENTER	CONCUR 03/03 VOTE: 14-2		3/06
SB0120	HERTEL, JOHN 1/30	2/06	REVISE NAME AND FUNCTION OF MONTANA CENTER FOR THE AGED	CONCUR 03/01 VOTE: 15-0		3/02
SB0124	CRISMORE, WILLIAM 2/06	3/10	MODIFY SANITARY INSPECTIONS TO BE DISCRETIONARY PUBLIC HEALTH INSPECTIONS	CONCUR 03/10 VOTE: 8-0		3/13
SB0134	KLAMPE, TERRY 2/15	3/08	REQUIRE HEALTH CARE PROVIDER NOTIFICATION OF FINANCIAL INTEREST IN REFERRALS	DO NOT CONCUR 03/15 VOTE: 8-8		
SB0150	WATERMAN, MIGNON 1/24	1/30	ALLOW LIMITED DISCLOSURE OF NONIDENTIFYING ADOPTION INFORMATION; CON INTMEDY	CONCUR AS AMENDED 03/03 VOTE: 14-0		3/06
SB0158	WATERMAN, MIGNON 2/20	3/01	LONG-TERM CARE REFORM	CONCUR 03/15 VOTE: 16-0		3/16
SB0209	SWYSGOOD, CHUCK 2/15	3/08	REFORM WELFARE; AUTHORIZE SRS FAIM PROGRAM AND FOOD STAMP PROGRAM	CONCUR AS AMENDED 03/15 VOTE: 16-0		3/16
SB0217	DOHERTY, STEVE 2/15	3/03	CLARIFY INDIAN CHILD WELFARE SPECIALIST QUALIFICATIONS	CONCUR 03/03 VOTE: 14-0		3/06
SB0223	KEATING, TOM 2/20	3/06	EXPAND COVERAGE OF MEDICAID MANAGED CARE MENTAL HEALTH	CONCUR 03/15 VOTE: 12-4		3/16
SB0226	KEATING, TOM 2/22	3/10	REQUIRE LICENSE TO PRACTICE OR REPRESENT TO BE A PROFESSIONAL COUNSELOR tabled 3/22	CONCUR AS AMENDED 03/31 VOTE: 13-3		4/04
SB0236	WATERMAN, MIGNON 2/20	3/01	MEDICAID ESTATE RECOVERIES	CONCUR AS AMENDED 03/15 VOTE: 11-5		3/16

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DUANE GRIMES**, on March 6, 1995, at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. John C. Bohlinger, Vice Chairman (Majority) (R)
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. Bill Carey (D)
Rep. Antoinette R. Hagener (D)
Rep. Deb Kottel (D)
Rep. Bonnie Martinez (R)
Rep. Brad Molnar (R)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)
Rep. Susan L. Smith (R)
Rep. Loren L. Soft (R)
Rep. Kenneth Wennemar (D)

Members Excused: None

Members Absent: Rep. Dick Green (R)

Staff Present: David Niss, Legislative Council
Jacki Sherman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing:	SB 310, SB 240, SB 223
Executive Action:	SB 240 DO CONCUR
	SB 310 POSTPONED

{Tape: 1; Side: A; Approx. Counter: 000; Comments: n/a.}

HEARING ON SB 310

Opening Statement by Sponsor:

SEN. JUDY JACOBSON, SD 18, Butte, stated that SB 310 changes the Board of Medical Examiners to allow for Schedule II drugs to be prescribed by a physician assistant-certified (PA-C) for up to 34 days. They would like to see the PA-C and the nutritionist have full voting rights.

{Tape: 2; Side: A; Approx. Counter: 440; Comments: NA.}

EXECUTIVE ACTION ON SB 310

Motion: **REP. JOHN BOHLINGER MOVED THAT SB 310 BE CONCURRED IN.**

Discussion:

REP. DEB KOTTEL voiced her concern about the minimal degree of education that was required for PA-Cs to prescribe dangerous drugs in contrast to what is required for other positions. She said she was reluctant to extend that much time for prescriptions.

REP. CAROLYN SQUIRES mentioned that the PA-Cs have a good track record and have abided by the rules and regulations put on them from the beginning. She stated that during this legislature there have been various bills passed that have granted maximum duties to the minimally qualified and expressed wonder that now the committee was questioning the PA-Cs.

CHAIRMAN GRIMES told the committee that he was planning to amend the bill and postponed executive action.

{Tape: 2; Side: A; Approx. Counter: 640; Comments: NA.}

HEARING ON SB 223

Opening Statement by Sponsor:

SEN. TOM KEATING, SD 5, Billings, stated that SB 223 dealt with providing mental health care to recipients of Medicaid. He researched the financing of mental health recipients and found that if they are below the poverty level, they qualify for Supplemental Security Income (SSI) and are eligible for Medicaid. If they work to earn more money they lose their SSI. The law says that if they lose their last dollar of SSI then they lose their Medicaid. SB 223 elevates the eligibility standard of 200% of poverty. In the long run, the costs to the state will be reduced and there will be Medicaid savings. This will enable the recipients to keep working and participating in the treatment programs and thus move out of the system at some point.

Proponents' Testimony:

Peter Blouke, Director of the Department of Social and Rehabilitation Services (DSRS). EXHIBIT 4

{Tape: 2; Side: B; Approx. Counter: 30; Comments: The last part of EXHIBIT 4 ran onto side B.}

SEN. MIGNON WATERMAN, SD 26, Helena, served on the advisory committee that put together the Managed Mental Health Program.

She said that people need to remember that they are talking about managing care and not managing costs. One of the benefits for the state is that the costs of mental health services will be better managed and clients will receive better services. The services are not being expanded. The opportunities for Medicaid to pay are being expanded rather than the services being paid out of the general fund.

Bob Torres, Montana Chapter of the National Association of Social Workers (NASW), submitted written testimony **(EXHIBIT 5a)** and then read testimony on behalf of **Donna Hale. EXHIBIT 5b**

Kathy McGowan, Montana Council of Mental Health Centers, said that Montana was a bit behind the rest of the nation in regard to managed care. People are not satisfied with the way things are now and it is time to try and improve the system.

Hank Hudson, Department of Family Services (DFS), stated that the DFS shares the responsibility for managing the Youth Mental Health Program and supports the concept of improving the mental health system.

Candy Wimmer, Montana Board of Crime Control, representing the Governor's Youth Justice Council and the State Board for the Managing Resources for Montana, stated that juveniles would benefit from this improvement in mental health services.

{Tape: 2; Side: B; Approx. Counter: 425; Comments: NA.}

Kathy Standard, President of the Meriwether Lewis Institute. EXHIBIT 6

David Hemion, Mental Health Association. EXHIBIT 7

Patrick Pope, Executive Director of the Meriwether Lewis Institute, spoke on behalf of the **Montana Alliance for the Mentally Ill. EXHIBIT 8**

Dan Anderson, Administrator of the Mental Health Division in the Department of Corrections of Human Services, supported managed care and SB 223.

Jim Ahrens, President of the Montana Hospital Association, supported the bill.

Gloria Hermanson, Montana Psychological Association, supported the bill.

Bob Ross, Director of Region III Mental Health Center, Billings, mentioned that SB 223 had gained much support and agreement across the mental health community. There is a sweeping change in the mental health services being provided for Montanans. The status quo is not working and the changes that are and will be occurring will be beneficial to the recipients.

Opponents' Testimony: None

Informational Testimony: None

Questions From Committee Members and Responses:

REP. DEB KOTTEL asked of some ways that managed care would save the state $2 million. **Nancy Ellery, Administrator of Medicaid Services Division,** explained that the costs are reduced by better coordinating the services and access to care will be increased.

{Tape: 3; Side: A; Approx. Counter: 00; Comments: NA.}

REP. KOTTEL asked what the chances were of getting the waiver. **Ms. Ellery** answered that there was a good chance of getting the waiver approved, they just don't know when.

REP. BRAD MOLNAR asked if this was the program that was on the video that was going around the state a little while ago and who the contractor would be. **Mr. Anderson** said that it was the video and referred the question. **Ms. Ellery** stated that seven or eight companies have expressed interest but everyone is waiting for the waiver. There are three to four companies with extensive managed care experience.

REP. MOLNAR asked if any of those companies were currently running entire state programs and why couldn't they manage it by themselves. **Mary Dalton, DSRS,** knew of only one that is running a statewide program and that is in Massachusetts. They have been to Montana to talk to the department but haven't placed a bid yet. She stated that they needed to hire a company that will have expertise in managing mental health services and have responsibility on all ends of the continuum instead of trying to manage it by themselves.

REP. MOLNAR stated that he could see holes in what was being proposed. **Ms. Dalton** assured the committee that under the system, the advisory council previously mentioned would also be assisting them and would be open to public comment. An independent evaluator who will come in and make sure of the quality of care is required to have a waiver.

REP. MOLNAR asked if the parents of a child could sue the contractor in an appeals situation and asked about the requests for proposal (RFP). **Ms. Dalton** said she could not give a legal opinion to that question, but thought that the parents could sue. She didn't know how far they would get in the process.

Mr. Anderson stated that they were quite competent to write an RFP for the program and Managed Resources of Montana (MRM) has not come up with an RFP process for children in treatment.

REP. MOLNAR questioned if they lack the capability of doing this on their own with the current in-house staff. **Mr. Anderson**

answered that it would take time and a different staff to do that as a state agency. They do not have the resources.

{Tape: 3; Side: A; Approx. Counter: 530; Comments: NA.}

REP. LOREN SOFT asked for some examples of other states that have done what the state of Montana is trying to do in regard to managed care.

Ms. Ellery mentioned that there were about 22 other states that were looking at or implementing managed care in mental health. Massachusetts is the best example and they have a statewide contract with a behavioral health company and their first evaluation showed that the state saved about $47 million. They had a 22% reduction of their mental health expenditures in one year.

REP. SOFT asked if any of the companies that might bid for the contract were in-state and what would be the estimated annual management fee for the managed care contract. **Ms. Ellery** thought that the Regional Mental Health Centers might be working with the state on a proposal.

Ms. Dalton stated that there was a federal upper limit cap in order to receive a waiver. The contractors would get all the money and they have to be able to administer the program and deliver the services so it won't be broken out as a management fee like other contracts. The contractors would be audited.

REP. SOFT inquired about the other states and if they had been able to pull out the management fee for the services. **Ms. Ellery** stated that Massachusetts had set it up as a full risk basis on the contract. The company can go either full risk or partial risk and reserve for profit and loss.

REP. SOFT asked how the funding will work and what will happen if all the funds were put into the contractor. **Ms. Ellery** stated that there will be three "pots" of money. Each one will be used for a different group. The Medicaid pool will be capitated out on a per client per month basis to the managed care company. This area is going to be expanded. The second pool of money is the expanded population. That money will also go to the managed care company in a fixed amount per month. The third pool is the Warm Springs State Hospital. The state dollars that would have been spent at the hospital also allocated out to the contractors.

REP. SOFT asked what the risks would be for the providers. **Ms. Ellery** thought that the providers would see this as an improved system that won't be tied into Medicaid rates and arbitrary limits. They will negotiate directly with the managed care company for their services.

{Tape: 3; Side: B; Approx. Counter: 00; Comments: NA.}

The contractors are much more flexible and more efficient than the state.

REP. SOFT questioned if the contractors would work with the providers on a per client per month capitated basis. **Ms. Ellery** replied that it would vary according to the service.

REP. ELLEN BERGMAN asked the sponsor if the bill would have to go to appropriations before it could go anywhere. **SEN. KEATING** answered that it had already gone to the subcommittee and there is a $2 million general fund savings on it.

REP. BERGMAN asked if it was expanding the mental health care services and the sponsor said that it was not necessarily expanding services but that the goal would be that more people would be served more appropriately and level the expenses.

REP. SUSAN SMITH asked if the 22% decrease referred to the overall decrease or in the decrease of expenditures plus the cost of the managed care. **Ms. Ellery** answered that it was a 22% difference between what they would have spent without managed care and what their actual expenditures would have been without the program.

REP. S. SMITH asked what incentive the contractor had to do a good job. **Ms. Ellery** stated that they had every incentive to do a good job because they are nationally recognized at what they do and how much the premium would change every year would be controlled.

REP. S. SMITH asked if the goal isn't to have fewer people needing health care and if they are going to get better, then there should be fewer people providing services for them if they are doing a good job and thus reducing the costs.

Ms. Ellery replied that it should reduce costs for some people, but there are going to be some people who aren't getting the services now and money is being spent on them when they end up getting sent to the state hospital where services could be provided. What the contractors would not have control over is how many people become eligible. There has to be some way to account for more people coming into the system than were expected.

REP. S. SMITH inquired how many full-time employees they had now and how many they would add for the managed care center. **Ms. Ellery** answered for SRS and stated that there was one person now and they would need one person when the system was in place.

Mr. Anderson also answered that there were five people in their office in Helena and don't anticipate reducing the number, but by the next legislature will reevaluate the jobs.

REP. MOLNAR asked where they were at currently regarding the poverty level. **Ms. Ellery** explained that it depended on many factors. Medicaid eligibility for a pregnant woman or a child under age six is 133% of poverty. For children from age seven to twelve it is 100% of poverty. For people age twelve and above the federal poverty level goes down to 40.5%. The federal government has mandated that each year one more age group needs to be added on to the 100%. She stated that Wyoming is less than Montana and Utah is going through an expansion of 185%.

REP. MOLNAR described the Supreme Court's ruling that under the right to travel in any state, potential clients are entitled to services. He asked if the surrounding states have a lower poverty level, what would stop them from coming to Montana to receive more mental health services. **Ms. Ellery** replied that someone could do that right now and Medicaid federal law does not allow a residency requirement. The expanded group will have a sliding scale based on the ability to pay.

REP. TONI HAGENER wanted to know how this would work in rural areas with their current staff and facilities and services. **Ms. Ellery** said that this would be a benefit to those in rural areas because the managed care entity has the resources to go out and try to recruit providers that may not be there. The contractors have to ensure statewide access to care, with the use of telecommunications and other resources. They will use the current services plus those that would be beneficial to add for that area and need.

{Tape: 3; Side: B; Approx. Counter: 520; Comments: NA.}

Closing by Sponsor:

SEN. KEATING remarked that in mental health treatment not every patient will get well. There is not a program anywhere that is 100% successful. At one time Warm Springs had 2,000 patients. Then regional mental health centers were established for after care. Warm Springs has been downsized and more treatment is being handled in communities. This includes sub-acute care and acute care which is the most expensive. There are too many different kinds of mental illness to deal with as a whole. Each is individual and unique. Mental illness seems to be generational, so they will never get rid of the product. There will be a demand as long as there are families who are mentally ill. SB 223 is not MRM in any way, shape or form. It is an opportunity to privatize the delivery of mental health care under a program through a private organization that has demonstrated actuarially that they can deliver quality mental health services for much less cost that what is being paid presently.

HOUSE OF REPRESENTATIVES

Human Services and Aging

ROLL CALL DATE 3-6-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. John Bohlinger, Vice Chairman, Majority	✓		
Rep. Carolyn Squires, Vice Chair, Minority	✓		
Rep. Chris Ahner	✓		
Rep. Ellen Bergman	✓		
Rep. Bill Carey	✓		
Rep. Dick Green		✓	
Rep. Toni Hagener	✓		
Rep. Deb Kottel	✓		
Rep. Bonnie Martinez	✓		
Rep. Brad Molnar	✓		
Rep. Bruce Simon	✓		
Rep. Liz Smith	✓		
Rep. Susan Smith	✓		
Rep. Loren Soft	✓		
Rep. Ken Wennemar	✓		

EXHIBIT 1
DATE 3/6/95
SB 223

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

TESTIMONY OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

(Re SB 223 - An Act Relating to Medicaid Managed Care Mental Health Services)

In conjunction with the Departments of Corrections and Human Services and Family Services, and with the cooperation of the Office of Public Instruction and the Commissioner of Insurance, the Department of Social and Rehabilitation Services has been doing extensive planning for a system of managed care for all publicly funded mental health services in Montana. That planning was required by HB33 as passed by the 1993 Special Session. The bill before you will accomplish a number of changes in law that are necessary to implement the program we have designed.

Working with the Department of Corrections and Human Services we determined that to have an effective and comprehensive managed care program it was necessary to include all state-funded mental health services under the new system. It then became necessary to find a way to include those people whose mental health services are currently paid, in full or in part, by the state general fund. To do so we have proposed to expand Medicaid eligibility, for mental health services only, to Montanans with an income of up to two hundred percent (200%) of the Federal Poverty Level. For a family of four that would equate currently to an annual income of $29,600. Approximately forty percent (40%) of Montana families fall within this standard. We are proposing a graduated fee schedule under which persons qualifying for this expanded eligibility would pay a portion of their mental health treatment costs. This bill will authorize the Medicaid program to accomplish this.

Another important component of our proposed system is to have the managed care contractor perform eligibility determinations for people qualifying under this expanded category. SRS has insufficient personnel available for what will be a large workload expansion. This bill will allow us to have eligibility determinations for mental health managed care performed by an entity other than the county welfare offices.

After consultation with the Commissioner of Insurance, we have determined that some adjustments are also needed in the insurance law to implement our managed care program. First, we are asking that the contractor under the Medicaid mental health managed care program be exempt from requirements that they be licensed as an insurance company. We believe that few of the national managed care companies which have expressed an interest in bidding on our program would be able or willing to meet the extensive requirements for becoming an insurer in Montana. Neither we nor the Commissioner believe it is necessary. We will have extensive financial reporting and solvency requirements in our managed care contract, and the Commissioner's staff has agreed to assist us in evaluating the financial abilities of the bidders and in establishing solvency requirements.

The insurance laws must also be changed in order for us to require that the managed care contractor be responsible for arranging for all Medicaid mental health services. Currently health maintenance organizations are required by law to provide behavioral health services. This bill will remove those services from

"AN EQUAL OPPORTUNITY EMPLOYER"

the package required of HMOs serving Medicaid clients. Then we can enroll Medicaid recipients in HMOs for physical health care without weakening the effectiveness and comprehensiveness of our mental health initiative. This exemption will avoid the necessity of creating an entire new set of regulations for this unique situation.

This bill also addresses some minor changes needed in the mental health laws to permit the managed care program to work effectively. It authorizes Montana State Hospital and the Center for the Aged to receive payments from the managed care contractor and to use those payments for the operation of the institutions. When the funds normally allocated to them by the legislature are included in the capitation payment to the managed care contractor, this will allow the two institutions to be paid as providers under the managed care system.

Finally, the bill makes two additional minor changes in the mental health statutes. One allows the Department of Corrections and Human Services to designate an entity other than the community mental health centers to screen voluntary admissions to Montana State Hospital. This gives the department additional flexibility in anticipation of a changing array of providers under managed care. Another allows the department to limit services if sufficient funding is unavailable.

This diverse amalgam of changes to existing laws is needed not to authorize a mental health managed care program, which was done by the 1993 Special Session, but to allow the program to go forward as designed and as efficiently as possible. It is important to note that Montana will need to receive waivers to a number of federal regulations in order to implement this program. If this does not come about, all of these changes will have no effect on the operation of the state's mental health system.

On behalf of the Department of Social and Rehabilitation Services, I urge you to pass SB 223. Thank you for the opportunity to speak to this important bill.

Peter S. Blouke, PhD
Director
Department of Social and Rehabilitation Services

EXHIBIT 4
DATE 3-6-95
SB 223

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

3/7/95

TO:

Representative Grimes	Representative Ahner
Representative Bohlinger	Representative Bergman
Representative Carey	Representative Green
Representative Hibbard	Representative Kottel
Representative Martinez	Representative Molnar
Representative Simon	Representative Soft
Representative Squires	Representative Wennemar
Representative Liz Smith	Representative Susan Smith
Representative Hagener	Representative Elliott

FROM: Nancy Ellery, Administrator
Medicaid Services Division
Mary E. Dalton acting for

On Monday, March 6, during the hearing on SB 223 before the House Human Services and Aging Committee you asked for more information regarding: 1) AFDC eligibility in surrounding states; and 2) the Massachusetts Medicaid managed mental health program.

I am enclosing a very brief synopsis of the Massachusetts evaluation. Massachusetts is the only state-wide program that I am aware of who has had an independent evaluation of their results. Other states have not been in operation long enough. I have also attached an article about states which are considering managed mental health programs.

I have included the AFDC payments as of 12/93 for all states. Although Montana payments are derived as a percentage of the federal poverty level, other states derive their payments in a variety of different ways. For this reason, comparisons are expressed in terms of payment standards. If you have further questions regarding eligibility, Penny Robbe of the Family Assistance Division or her staff are available to answer your concerns. I do want to reiterate that we will be increasing eligibility only for mental health services to 200% of the federal poverty level. The majority of persons who would meet the expanded eligibility criteria are currently receiving services paid for with 100% general fund. People eligible under this provision will not be eligible for other Medicaid benefits. There will be a sliding fee scale used based on income to require recipients to pay a portion of the cost of care.

Please feel free to contact me if you have any other questions. My phone number is 444-4141.

c: Peter Blouke
Penny Robbe
Mary Dalton

quality assurance process to monitor health outcomes.—***May 1994, GAO/HEHS-94-152-BR, 42 pages***

• For copies, call (202) 512-6000 or fax (301) 258-4066.

HHS News

Health Care Financing Administration

The rate of increase in Medicaid spending dropped to 11.5% in fiscal year 1993, down sharply from the 25% rise in FY 1992. Total Medicaid outlays were $131.8 billion in 1993. The number of people covered by Medicaid in FY 1993 rose 8.1% to about 33.4 million between FY 1992 and FY 1993, thus per capita Medicaid spending rose less than 4%. In FY 1992, Medicaid enrollment increased 9.2% to 30.9%. The slowing of the growth rate is attributed by HCFA to cost control measures that have been implemented; redefinition of which tax and donation arrangements are permitted to increase state Medicaid budgets; a stronger economy, which has put people back in the labor force; and greater use of managed care programs for Medicaid enrollees. —***5/6/94, 3 pages***

• For copies, call HTR at (800) 945-8816.

Evaluation of the Massachusetts Medicaid Mental Health/Substance Abuse Program

Heller School for Advanced Studies in Social Welfare, Brandeis University

A contracted managed care program in Massachusetts, that provides mental health and substance abuse services to 375,000 enrollees in the state's assistance programs, has achieved positive cost savings, but its impact on improving access and quality is uncertain. For FY93, Medicaid mental health and substance abuse expenditures were $46.8 million, 22% lower than projected levels without the managed care program. In 1993, mental health costs per enrollee (adjusted for inflation) declined 19%, while substance abuse costs per enrollee fell 48%. Actual expenditures for ambulatory care were 12.9% below predicted levels and 24-hour care, 38% below, after adjustment for enrollment, utilization trends, and inflation. Because of changes in the provider reimbursement methods, only $42 million of the $46.8 million in total savings could be attributed to managed care. The total number of users per 1,000 enrollees increased by 4.6% between FY92 and FY93, but a survey of 98 providers showed that the providers did not think there has been any change in access under managed care. On the issue of quality, there has been no change based on recidivism rates and provider reports. There was no system in place to evaluate patient satisfaction.—***J. Callahan and D. Shepard, 1/24/94, 200 pages*** (report plus executive summary), $3 (executive summary only)

• For copies, send check to Sylvia Pendleton, Heller School, Brandeis University, P.O. Box 9110, Waltham, MA 02254.

NANCY
FYI

Handout 2/8/94
AG mtg

INDUSTRY STATISTICS: Medicaid Moving Toward Managed Behavioral Health Programs

EXHIBIT 4
DATE 3-6-95
SB 223

Twenty state Medicaid plans are either actively seeking a vendor to manage behavioral health benefits on a risk basis or are developing behavioral health programs. Thirteen states have already entered into agreements with behavioral health utilization review (UR) programs. And, at least four states have risk-based Medicaid managed behavioral health programs in place -- Utah, Massachusetts, Oregon (counties are at risk), and South Carolina (community mental health centers are at risk). These are the results of an *OPEN MINDS* survey of state Medicaid programs, with 38 states participating.

A difficulty in the development of risk-based contracts for Medicaid behavioral health benefits is lack of information about how contract dollars are spent. According to a study by the National Association of State Mental Health Program Directors Research Institute, approximately $1.7 billion were expended on Medicaid behavioral health services by state mental health agencies during fiscal year 1990 -- 58.8% funded by the federal government and 41.2% by the states. Of this $1.7 billion, 0.8% was expended on case management, 18.3% through the clinic option, 7.5% through the rehabilitation option, 24.7% on inpatient hospitalization for those under 21 years of age, 32.9% on inpatient hospitalization for those over 65 years of age, and 15.9% on other services. These figures are of limited use because of difference among states in what Medicaid behavioral health benefits are controlled by state mental health agencies.

States Evaluating Medicaid Managed Behavioral Health

California
Colorado
Florida
Illinois
Indiana
Kansas
Maine
Michigan
Minnesota
Montana
Nevada
New Mexico
North Carolina (children only)
Ohio
Pennsylvania
South Dakota
Vermont (children only)
Washington
Wisconsin (children only)
Wyoming

States With Medicaid Behavioral Health UR Programs In Place

Alaska (Professional Review Of Washington)
Colorado (Colorado Foundation For Medical Care)
Connecticut (First Mental Health)
Idaho (Peer Review Organization Of Washington)
Illinois (Unknown)
Indiana (EDS)
Kansas (Mental Health Consortium & Kansas Foundation For Medical Care)
Kentucky (MOMI)
Montana (First Mental Health)
Nevada (Nevada Peer Review)
New Jersey (BCBS Of Pennsylvania)
New Mexico (BCBS Of New Mexico)
North Carolina (First Mental Health)

During fiscal year 1990, six states (Arizona, Florida, Minnesota, Ohio, Oregon, and Vermont) exercised the Medicaid rehabilitation option, which covers behavioral health services otherwise not covered by Medicaid. Almost 30 states now exercise the option.

Most states have maintained unlimited behavioral health benefits, while eight states have limits:

- Alaska: Limits on rehabilitation, case management, activities therapy, home therapy, and day treatment.
- Colorado: Inpatient treatment limited to 45 days.
- Idaho: Partial hospitalization limit of 56 hours per week.
- Illinois: Inpatient treatment limited to 45 days.
- Kansas: Minimal coverage outside of CMHCs. In CMHCs, partial hospitalization limited to 1,560 hours per year; group/family therapy to 40 hours per year; and individual therapy to 32 hours per year.
- Maine: Inpatient limited to three days for adults.
- Nevada: Inpatient treatment limited to five-day assessment, with additional days preauthorized. No coverage of partial hospitalization.
- Ohio: Inpatient treatment is limited to 10 days.

As state governments evaluate their options for Medicaid, *OPEN MINDS* will continue to keep you abreast of these changes. The study referenced above is available from NASMHPD Research Institute, Inc., 66 Canal Center Plaza, Suite 302, Alexandria, Virginia 22314, 703-739-9333.

By Arthur R. Smith & Monica E. Oss

METHODS USED BY STATES[1] TO DETERMINE THE AMOUNT OF THE ASSISTANCE PAYMENT FOR BASIC NEEDS[2] IN AID TO FAMILIES WITH DEPENDENT CHILDREN, BY STATE, AS OF OCTOBER 1, 1990

State meets the full amount of its need standard for families[3] of all sizes . . . . . .16 States

Alaska	Kansas	New Hampshire	North Dakota
Connecticut	Massachusetts	New Jersey	Oregon
Delaware	Minnesota	New Mexico	Rhode Island
Guam	Nebraska	New York	South Dakota

State meets amount of its need standard for a smaller size family but limits payments to larger families . . . . . .1 State

California — Income is subtracted from the statutory maximum; payment is the deficit. Statutory maximums equal the need standard for families of one through eight. Families of nine or more receive less than the need standard; the highest allowable payment is $1468 for families of ten or more.

State does not meet the full amount of its need standard for families of any size . . .37 States

Limitations on payments are made by the following methods:

Income is subtracted from the full need standard, and

Payment is the deficit or maximum by family size, whichever is less . . . . . 5 States

Georgia	Maximum equals approximately 66 percent of the full standard.
Maine	Maximum equals 69.4% of full standard.
Michigan	Maximum equals "payment standard"; need standard equals 120% of "payment standard".
Tennessee	Maximum equals 47.5% of full standard.
Wyoming	Maximum equals varying percentage of full standard.

Payment is a percent of the deficit between full need standard and countable income . 4 States

Colorado/84.75%	South Carolina/47.8%
North Carolina/50%	Utah/75%

Payment is a percent of the deficit or the maximum by family size, whichever is less . . 2 States

Kentucky/55% or maximum[4]	Mississippi/60% or maximum

A percentage reduction is applied to the full standard. Income is subtracted from the reduced standard, and

Payment is the deficit . . . . . .21 States

Alabama/varies	Idaho/57%	Montana/81.5%	Puerto Rico/50%
Arizona/47.2%	Illinois/47%	Nevada/60%	Texas/32%
Arkansas[5]/29%	Iowa/85.7%	Ohio/43.05%	Vermont/66%
D.C./60.1%	Louisiana/29%	Oklahoma/68%	Virgin Islands/80%
Florida/varies	Maryland/72.3%	Pennsylvania/68.625%	Wisconsin/80%
Hawaii/62.5%			

Payment is the deficit or the maximum, whichever is less . . . . . 5 States

Indiana/90% or maximum	Washington/55.1% or $985 (8 or more)
Missouri/93.66% or maximum	West Virginia/50% or $477
Virginia/90% or area maximum	

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1 Each State sets its own need standards, both in terms of subsistence recognized and in terms of the amounts of money allowed to cover them. The standard is always related to the number of persons in the assistance unit.

2 Those States which set separate standards for basic needs and for special circumstance items and which do not meet 100% of their need standards may combine the amount allowed for special needs with the amount for basic needs before applying any reduction, or they may add the full amount for special needs to the reduced amount for basic needs. This table is based upon payment methods for basic needs only.

3 The word "family" is used loosely to mean the persons comprising an assistance unit as defined by State and Federal regulations.

4 The need standard stops at family size seven; there are no incremental increases for families of more than seven.

5 The need standard stops at family size nine; there are no incremental increases for families of more than nine.

TABLE 2-4.

HCFA STATE PROFILE DATA SYSTEM
AFDC PAYMENT STANDARDS (DOLLARS)
EFFECTIVE MEDICAID STATE PLAN AS OF 12/31/93

STATE	1-PERSON	2-PERSONS	3-PERSONS	4-PERSONS	5-PERSONS	RURAL VARIANCES
ALABAMA	100.00	123.00	149.00	168.00	194.00	N
ALASKA	498.00	845.00	950.00	1055.00	1160.00	Y
ARIZONA	567.00	765.00	964.00	1162.00	1360.00	Y
ARKANSAS	81.00	162.00	204.00	247.00	286.00	N
CALIFORNIA	326.00	535.00	663.00	788.00	899.00	N
COLORADO	214.00	280.00	356.00	432.00	512.00	N
CONNECTICUT	411.00*	524.00*	649.00*	756.00*	853.00*	N
DELAWARE	201.00	270.00	338.00	407.00	475.00	N
DIST OF COL	450.00	560.00	712.00	870.00	1002.00	N
FLORIDA	180.00	241.00	303.00	364.00	426.00	Y
GEORGIA	155.00	235.00	280.00	330.00	378.00	N
HAWAII	357.00	480.00	602.00	725.00	846.00	N
IDAHO	205.00	251.00	317.00	382.00	448.00	N
ILLINOIS	212.00	268.00	367.00	414.00	485.00	Y
INDIANA	155.00	255.00	320.00	385.00	450.00	N
IOWA	183.00	361.00	426.00	495.00	548.00	N
KANSAS	265.00	347.00	422.00	488.00	547.00	Y
KENTUCKY	162.00	196.00	228.00	285.00	333.00	N
LOUISIANA	72.00	138.00	190.00	234.00	277.00	Y
MAINE	214.00	337.00	453.00	569.00	685.00	N
MARYLAND	179.00	317.00	406.00	489.00	566.00	N
MASSACHUSETTS	392.00	486.00	579.00	668.00	760.00	N
MICHIGAN	305.00	401.00	489.00	593.00	689.00	Y
MINNESOTA	437.00	532.00	621.00	697.00	773.00	N
MISSISSIPPI	218.00	293.00	368.00	443.00	518.00	N
MISSOURI	136.00	234.00	292.00	342.00	388.00	N
MONTANA	235.00	318.00	401.00	484.00	567.00	N
NEBRASKA	222.00	293.00	364.00	435.00	506.00	N
NEVADA	246.00	309.00	372.00	435.00	498.00	N
NEW HAMPSHIRE	388.00	451.00	516.00	575.00	631.00	N
NEW JERSEY	162.00	322.00	424.00	488.00	552.00	N
NEW MEXICO	209.00	283.00	357.00	431.00	504.00	N
NEW YORK	119.10	189.50	253.00	326.70	402.70	N
NORTH CAROLINA	181.00	236.00	272.00	297.00	324.00	N
NORTH DAKOTA	221.00	333.00	409.00	501.00	569.00	N

EXHIBIT 4
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TABLE 2 -A- (CONT.)

AFDC PAYMENT STANDARDS (DOLLARS)
EFFECTIVE MEDICAID STATE PLAN AS OF 12/31/93

STATE	1-PERSON	2-PERSONS	3-PERSONS	4-PERSONS	5-PERSONS	RURAL VARIANCES
OHIO	203.00	279.00	341.00	421.00	493.00	N
OKLAHOMA	200.00	251.00	324.00	402.00	470.00	N
OREGON	310.00	395.00	460.00	565.00	660.00	N
PENNSYLVANIA	215.00	330.00	421.00	514.00	607.00	Y
RHODE ISLAND	327.00	449.00	554.00	632.00	710.00	N
SOUTH CAROLINA	124.00	167.00	210.00	252.00	295.00	N
SOUTH DAKOTA	293.00*	368.00*	417.00*	464.00*	512.00*	N
TENNESSEE	95.00	142.00	185.00	226.00	264.00	N
TEXAS	75.00	158.00	184.00	221.00	246.00	Y
UTAH	233.00	323.00	402.00	470.00	536.00	N
VERMONT	465.00	567.00	673.00	755.00	845.00	Y
VIRGINIA	220.00	294.00	354.00	410.00	488.00	Y
WASHINGTON	349.00	440.00	546.00	642.00	740.00	N
WEST VIRGINIA	145.00	201.00	249.00	312.00	360.00	Y
WISCONSIN	311.00	550.00	647.00	772.00	886.00	Y
WYOMING	195.00	320.00	360.00	390.00	450.00	N

* = DATA BASED ON PENDING STATE PLAN AMENDMENT

EXHIBIT 5
DATE 3/6/95
SB 223

Mr Chairman, members of the committee

My name is **Donna Hale**, I am a licensed clinical social worker who is **self-employed** as a psychotherapist.

Last year, during the special session, the department of Social and Rehabilitative Services introduced a bill for managed care of Medicaid mental health services. I spoke to express the great concern about this measure shared by those mental health providers who are self-employed, in private practice, and who provide the vast majority of Medicaid out-patient mental health services. In response to this testimony and the testimony of many others, the legislature added language to the bill requiring formation of an advisory committee and also requiring that the final drafts of the bill come to this legislature for action. I am here today to report to you on those measures.

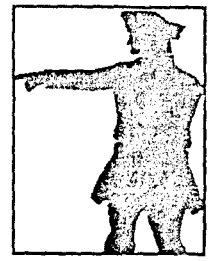
We all know that advisory committees can be paper tigers, without any real power. However, although I was initially suspicious of this process, I found that the committee that SRS chose to form indeed represented all those who were concerned or affected by this proposal. Each of the professional associations, the National Association of Social Workers, the American Psychological Association, and the National Association of Professional Counselors was invited to designate a representative to the committee. In addition, the committee included other private providers, representatives from the Mental Health Centers and the State Hospital, consumers, and representatives from the state agencies involved. We were given reams of material to read, we listened to presentations from persons from across the country, met for numerous hours, and were encouraged to make comments and ask questions. Our suggestions and concerns were listened to and responded to. **The measure you have before you represents the first time that I am aware of that the consumers of these services, the providers, both public and private, and the state agencies involved have worked**

together and forged a program that we all agree with. This has required tremendous effort and cooperation and I very strongly urge you to support our work by passing this bill. ~~In addition~~, I have heard a number of comments regarding this bill. First that the status quo is fine and can continue. I want you to know that it is not fine and that those of us who provide the bulk of the outpatient services cannot continue as we have been. In addition, I have heard suggestions that the state could manage this care ~~more~~ at less cost than bringing in a private organization. I believe that this is true, but only if you're willing the add the FTE's necessary and provide the financial resources for their training and wait for the several years that would be necessary for them to gain sufficient knowledge to design such a program. Several years that would be very costly. Again, I strongly believe in the process that has been utilized and in this bill. Please provide us with your support.
Thank you.

EXHIBIT 6
DATE 3/6/95
SB 223

Meriwether Lewis Institute

562 Fifth Avenue
Helena, Montana 59601
(406) 442-7416



For: HUMAN SERVICES & AGING COMMITTEE
Date: March 6, 1995

Mr. Chairman and Members of the Committee:

My name is Kathy Standard and I am serving my second term as President of the Meriwether Lewis Institute. The Meriwether Lewis Institute is Montana's only non-profit corporation that was created solely by and for people who have mental illness. The Board of Directors, the Executive Director, and all voting members have a mental illness. I have a mental illness that I am finally able to manage through a combination of medication, therapy and peer support. I owe much of my current stability to good psychiatric care and an excellent therapist, both provided by the public mental health system. I am also very lucky that I am well enough to fight for what I need from the mental health system - many people with mental illness do not have access to the supports necessary for getting their needs met, and may not even be encouraged to evaluate what their own needs <u>are</u>.

What we currently have in Montana is a care-taking system, where mental health centers, the State Hospital, and other providers have more to gain financially if we are sick than if we are well. This is not particularly their fault. The problem lies with a mental health system based on services that pay money to the <u>provider,</u> not on services designed to help mental health consumers learn to manage their lives and be as independent as possible. One of the basic tenets of the Meriwether Lewis Institute is that every mental health consumer has the <u>right</u> to reach his or her full potential, whatever that may be. Montana's current mental health system, as a whole, is <u>not</u> conducive to helping consumers reach their full potential.

5e

Our Executive Director and I also serve on the Mental Health Managed Care Advisory Group, and have spent many, many hours studying and researching the concept of managed care. The Meriwether Lewis Institute represents a large number of the people who will be affected by mental health managed care, and we have critically evaluated what we've learned. Despite our numerous concerns, we believe that the Montana mental health system's only hope of operating efficiently and effectively is under a managed care plan. Medicaid has included mental health consumers in its planning for managed care, and we believe they will continue to be willing to listen to and address our concerns as they develop a realistic Mental Health Managed Care program. It is our understanding that services will be designed to meet the needs of consumers, and will provide the continuum of care that is missing now but is so desperately necessary to enable consumers to begin healing and to maintain the stability that can keep us alive. If designed correctly, managed care can reduce our dependency on the system and increase our ability to function independently. It could allow many of us to support ourselves and pay taxes again. If we can receive the services we need as individuals, we can finally live our lives with dignity and self-respect, no matter what stage our illness is in.

During the past 5 years of both regular and special Legislative Sessions, mental health services have been cut time and time again. Consumers have stood here and literally begged the Legislature to give us the opportunity to rebuild our lives, yet the programs and services we need in order to even survive are continually damaged by cuts. On behalf of Montana mental health consumers, I ask you to support Mental Health Managed Care and enable us to learn healthier, more effective ways to live with our mental illnesses.

Thank you.

EXHIBIT 7
DATE 3/6/95
SB 223

TESTIMONY OF DAVID HEMION
PUBLIC POLICY COORDINATOR
MENTAL HEALTH ASSOCIATION OF MONTANA
SB 223 - MENTAL HEALTH MANAGED CARE
March 6, 1995

The Mental Health Association of Montana represents some 1,200 mental health consumers, providers, family members and others interested in achieving victory over mental illness. On behalf of MHA, here are its positions on mental health managed care.

1. MHA SUPPORTS A PRE-PAID MANAGED MENTAL HEALTH PLAN, COMBINING STATE AND MEDICAID FUNDS.

MHA believes that managed care offers a solution to both cost-containment and quality service delivery. The American Academy of Actuaries has concluded that managed care for mental health services can save between 30 to 40 percent over unmanaged fee-for service or minimally managed delivery systems. AAA conducted studies of the Health Security Act of 1993 and estimated that costs for treatment of mental illnesses and substance abuse would drop: from $240 to $305 per person annually for unmanaged care to $45 to $165 per person under managed care.

In actual experience, large corporate health plans track these estimates. Bell South reduced its spending for mental health benefits by 30 percent over three years. Alcan Aluminum reduced its annual mental health per capita claims from $170 to $ $70 over two years.

Public sector experience is similar. A Brandeis University study of the mental health Medicaid managed care system for the state of Massachusetts, implemented in 1991, showed a 22 percent reduction over anticipated costs and actual savings of $23 million.

We need to temper our expectations about Montana's projected system. Please remember that savings for Medicaid-eligible clients may not be as great as general populations, as those included are in varying conditions of poverty, which places them at higher risk for mental illnesses and health problems.

The Brandeis study also found that quality of service did not suffer, as indicated by a decline in recidivism rates of about 20 percent. Access also improved with increases in numbers of users of 22 percent.

Imagine that. A decrease in costs, increase in clients served with quality maintained or improved.

2. MHA SUPPORTS RETAINING SAVINGS WITHIN THE MENTAL HEALTH SYSTEM

We believe that Montana needs to retain funds saved by managed care, at least through initial years, to fund service gaps, improving prevention, early intervention and access, especially for difficult to serve populations, such as those in remote areas.

3. MHA SUPPORTS INCLUDING SERVICES PROVIDED BY MONTANA STATE HOSPITAL IN MANAGED CARE.

MHA expects all patients admitted by MSH, except forensic patients, to be included. We anticipate that managed care will increase treatment of patients at the community level, decrease admissions to MSH and discharge patients sooner and to an improved after care continuum.

4. MHA CONTINUES TO EXPRESS CONCERN REGARDING THE COMBINING OF PUBLIC FUNDS TARGETED TO CHILDREN'S SERVICES WITH FUNDS FOR ADULT TREATMENT.

Our concerns are two-fold. First, Montana is working hard to overcome a past lack of coordination of children's services, primarily through the MRM program. We are concerned that the gains MRM has made may be rolled back, unless funding for children's services is somehow protected. We support the recommendation of Dan Anderson of the Department of Corrections and Human Services to earmark funding for children's services to prevent funding shifts to adult services.

Our second concern is that actions to date in this Legislative session indicate that inadequate funding will be provided for children's services. The 50 percent cut in the MRM program and denial of funding for the Community Impact program are tragic. We urge the legislature to restore funding to levels recommended by the Governor for both these programs.

This concern also extends to adult services. Funding for community level crisis intervention and housing is the only way to prevent costlier hospitalization. The funding requested for these services must be restored by the Legislature.

To ignore this request invites an avoidable disaster for the mental health of the children of Montana. It also assures the failure of managed care, as we doubt any contractor would be willing to take on the task of managing an underfunded system.

5. MHA SUPPORTS EXPANDING COVERAGE TO 200 PERCENT OF POVERTY.

This is in the self-interest of all Montana tax payers, as it allows a shift from general fund-supported services to federal funding. It also provides a preventative measure by

assuring early intervention and treatment of mental illnesses for working Montanans who are uninsured or underinsured.

6.MHA APPRECIATES THE INITIATIVE OF THE DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES IN PURSUING MANAGED CARE AND ITS RESPONSIVENESS TO QUESTIONS AND CONCERNS RAISED BY MHA AND OTHERS.

SRS has been prompt in responding to detailed and extensive questions provided by MHA. We appreciate the opportunity to be represented on the Advisory Council by Joan-Nell Mcfadden, chair of MHA's Children's Committee and Candy Butler, MHA president-elect. We look forward to the opportunity to review and comment upon the RFP and to be actively involved in monitoring the implementation of managed care.

8. WE SUPPORT SB 223 AND URGE YOUR PASSAGE.

EXHIBIT 8
DATE 3/6/95
SB 223

March 6, 1995

Human Services and Aging Committee

Mr. Chairman and members of the Committee,

For the record, my name is Patrick Pope. I serve as Director of the Meriwether Lewis Institute and I am a consumer of mental health services. Marty Onishuk of the Montana Alliance for the Mentally Ill could not get here from Missoula today because of car trouble. I was asked to speak today on behalf of the Alliance.

The Montana Alliance for the Mentally Ill supports the concept of Managed Care. It feels that the current mental health system does not provide a continuum of care for people with mental illness. It is the hope of the Alliance that managed care will provide much improved, comprehensive services for consumers. Thank you.

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services DATE 3-6-95

BILL NO. SB 223 SPONSOR(S) Keating

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Randy Pobsen	SRS	X	
Bob Olsen	MHA	X	
Donna Hale	NASW	X	
Bob Ross	BIPS MENTAL HEALTH	X	
Gloria Hermanson	MT Psych Assn	X	
David Herrick	Mental Health Assoc.	✓	
Bev Toney	MT-Chap NASW	✓	
Cindy Wimmer	MBCC	✓	
KATHY McGOWAN	MCMHC	✓	
PAT POPE	MLI/MONTAMI	✓	
Dain Anderson	DCFS - MH	✓	
KATHY STANDARD	MERIWETHER LEWIS IDS	✓	
Joan-Nell MacFadden	DFS State Council	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORM ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

Joan-Nell MacFadden

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DUANE GRIMES**, on March 15, 1995, at 2:40 p.m.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. John C. Bohlinger, Vice Chairman (Majority) (R)
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. Bill Carey (D)
Rep. Dick Green (R)
Rep. Antoinette R. Hagener (D)
Rep. Deb Kottel (D)
Rep. Bonnie Martinez (R)
Rep. Brad Molnar (R)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)
Rep. Susan L. Smith (R)
Rep. Loren L. Soft (R)
Rep. Kenneth Wennemar (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Jacki Sherman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing:	SB 388	
Executive Action:	SB 209	DO CONCUR AS AMENDED
	SB 236	DO CONCUR AS AMENDED
	SB 223	DO CONCUR
	SB 158	DO CONCUR
	SB 134	DO NOT CONCUR AS AMENDED

{Tape: 1; Side: A; Approx. Counter: 000; Comments: n/a.}

REP. MARTINEZ opposed the bill as the system has changed so much and what is needed is real reform.

REP. S. SMITH agreed that this is not the best answer but it is better that what is in place now.

REP. L. SMITH clarified that the level of eligibility is 200% and asked if there was an increase.

CHAIRMAN GRIMES thought there was not an increase in eligibility.

REP. GREEN opposed the bill.

{Tape: 2; Side: B; Approx. Counter: 00; Comments: NA.}

CHAIRMAN GRIMES said that two years ago he and **Mr. Niss** tried to expand residency requirements in regard to welfare so the out-of-state people would be limited.

REP. BOHLINGER felt that the attempt was being made to move people off welfare and into life. It is a system that will help build a sense of dignity and self respect.

REP. SOFT stated his concern as to what types of measurements and outcome studies are going to be in place so that it can be seen what has or has not been done.

Ms. Robbe stated that they are contracting with the University of Montana to conduct an independent exhaustive evaluation of the project and welfare reform that will be outcome based.

REP. SIMON stated that this was a reasonable attempt to get some of the people out of the system and independent.

Motion: **Motion carried unanimously.**

{Tape: 2; Side: B; Approx. Counter: 190; Comments: NA.}

EXECUTIVE ACTION ON SB 223

Motion: **REP. LOREN SOFT MOVED THAT SB 223 BE CONCURRED IN.**

Discussion:

REP. SOFT stated that there would be a few risks involved for everyone with this welfare reform package. Managed care services require people to perform. By going right up to the 200% poverty level instead of phasing it in, expansion services will be able to be provided.

CHAIRMAN GRIMES clarified that mental health care is being changed to a managed care system. Poverty will be raised to 200%. General funding is being all put together to get more

federal dollars. A waiver is needed that will separate the mental health care services from all the rest.

REP. KOTTEL believed that this program will result in better coordinated services and increase better access to mental health care. The standard of care will rise also.

REP. SOFT clarified that the expansion services are in the area of mental health only. The sliding scale will be in effect for recipients to give their share.

REP. MOLNAR asked what the percentage of poverty levels were in bordering states. He raised the issue of people in bordering states coming over to Montana because of the higher poverty level.

CHAIRMAN GRIMES replied that community providers are the neutral party because they will be providing the services. This program will enable them to be better providers and more competitive and in tune to the needs of the clients.

REP. HAGENER supported the bill but stated her concern that a private management agency in an attempt to economize and make a profit will cause havoc in rural areas. Rural areas should not be overlooked in the development of these programs and services.

Vote: The motion carried 12-4 with REPS. MARTINEZ, MOLNAR, L. SMITH and S. SMITH voting no.

{Tape: 2; Side: B; Approx. Counter: 820; Comments: NA.}

EXECUTIVE ACTION ON SB 236

Motion: REP. JOHN BOHLINGER MOVED THAT SB 236 BE CONCURRED IN.

Discussion:

REP. BOHLINGER stated that 62% of the patients in nursing homes are on Medicaid and that some of the people on Medicaid are not poor. SB 236 is a way to recapture some of the public's investment in these people who have assets.

REP. GREEN supported the bill and said that anyone who can pay their bills ought to.

REP. L. SMITH opposed the bill and stated that the pressure should not always be coming from the state. It is not an incentive and there should be more support for people making these decisions.

{Tape: 3; Side: A; Approx. Counter: 00; Comments: NA.}

HOUSE OF REPRESENTATIVES

Human Services and Aging

ROLL CALL DATE 3/15/95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. John Bohlinger, Vice Chairman, Majority	✓		
Rep. Carolyn Squires, Vice Chair, Minority	✓		
Rep. Chris Ahner	✓		
Rep. Ellen Bergman	✓		
Rep. Bill Carey	✓		
Rep. Dick Green	✓		
Rep. Toni Hagener	✓		
Rep. Deb Kottel	✓		
Rep. Bonnie Martinez	✓		
Rep. Brad Molnar	✓		
Rep. Bruce Simon	✓		
Rep. Liz Smith	✓		
Rep. Susan Smith	✓		
Rep. Loren Soft	✓		
Rep. Ken Wennemar	✓		

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE 3-15-95 BILL NO. SB223 NUMBER _____

MOTION: Rep. Soft moved to "Do Concur"

un

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority	✓	
Rep. Carolyn Squires, Vice Chairman, Minority	✓	
Rep. Chris Ahner	✓	
Rep. Ellen Bergman	✓	
Rep. Bill Carey	✓	
Rep. Dick Green	✓	
Rep. Toni Hagener	✓	
Rep. Deb Kottel	✓	
Rep. Bonnie Martinez		✓
Rep. Brad Molnar		✓
Rep. Bruce Simon	✓	
Rep. Liz Smith		✓
Rep. Susan Smith		✓
Rep. Loren Soft	✓	
Rep. Ken Wennemar	✓	

12 4

HOUSE STANDING COMMITTEE REPORT

March 16, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **Senate Bill 223** (third reading copy -- blue) **be concurred in.**

Signed: _____
Duane Grimes, Chair

Carried by: Rep. Soft

Committee Vote:
Yes 12, No 4.

611137SC.Hdh

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

CONFERENCE COMMITTEE ON SENATE BILL 223

Call to Order: By CHAIRMAN TOM KEATING, on April 7, 1995, at 2:10 PM

ROLL CALL

Members Present:
Sen. Thomas F. Keating (R)
Sen. Larry L. Baer (R)
Sen. Mignon Waterman (D)
Rep. Royal C. Johnson (R)
Rep. Loren L. Soft (R)
Rep. Joe Barnett (R)

Members Excused: None

Members Absent: None

Staff Present: Karolyn Simpson, Secretary

Discussion: SB 223

Mary Dalton, Primary Care Bureau, Department of Social and Rehabilitation Services, said SB 385, which **REP. COBB** amended on the Floor of the House, is contingent on funding and it includes some language regarding a sliding fee scale, which HCFA (Health Care Financing Administration) told SRS they cannot do without a waiver. They are not willing to grant a waiver for this kind of expansion group because they are already covered. It will have no effect on SB 223 because, all it does is give mental health coverage and SRS would still do a carve out for the mental health portions, to children up to 133% who have physical health coverage too. It doesn't have any effect on savings that were promised in SB 223.

SENATOR KEATING asked if that is already in the statutes.

Mary Dalton said it is for kids up to age 6.

SENATOR KEATING said, it's his understanding that medical assistance must be provided for infants and pregnant women that do not exceed 133%.

Mary Dalton said it was taken up to age 19.

REP. BARNHART said **REP. COBB** asked if there was enough money for the 200% poverty level eligibility. She asked if they are covered or not.

Mary Dalton said SB 223 will be under federal waivers. It must be cost controlled for the life of the bill to the Federal Government, so projections are taken on what you are drawing, which is called a Federal upper ceiling, meaning so much of the Federal money can be spent but there can be matching funds. It will be a capitated pool so the Managed Care Program gets so many dollars to serve people to 200% of poverty. The State is not at risk, the Managed Care Company is taking that risk. People with any kind of serious mental illness are already being served to 200% through the Community Mental Health Centers.

REP. BARNHART asked if this is for adults and children.

Mary Dalton said yes.

SENATOR KEATING said there are 3 House Members and 3 Senate members present. He said the Committee is dealing with SB 223 and the amendments by the House, changing the bill from the Senate version.

EXECUTIVE ACTION ON SB 223

Motion: SENATOR WATERMAN moved to strike the House Amendments and return SB 223 to the Senate version.

SENATOR KEATING asked **SENATOR WATERMAN** if her motion is for the House to recede from its amendment.

SENATOR WATERMAN said yes.

Discussion: SENATOR KEATING said there is only one amendment, which is on page 11, lines 20-24, which deletes the 200% poverty eligibility level, and by accepting the motion for the House to recede from its amendment, then 200% of poverty will be the eligibility level for the Managed Care Program.

Vote: The motion to strike the House Amendments and return SB 223 to the Senate version CARRIED UNANIMOUSLY.

ADJOURNMENT

Adjournment: 2:15 PM

SENATOR TOM KEATING, Chairman

KAROLYN SIMPSON, Secretary

TK/ks

950407SC.223

Conference Committee
on SB 223
Report No. 1, April 7, 1995

Mr. President and Mr. Speaker:

We, your Conference Committee on SB 223, met April 7, 1995, and considered:

House Committee of the Whole amendment to the third reading copy dated March 29, 1995.

We recommend that SB 223 (reference copy - salmon) be amended as follows:

1. Page 11, line 24.
Following: "~~department.~~"
Insert: "The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department."

And that this Conference Committee report be adopted.

For the Senate:

Keating
Chair

Baer

Waterman

Amd. Coord.

Sec. of Senate

For the House:

Royal Johnson
Chair

Soft

Barnhart

ADOPT

REJECT

801459CC.SPV

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

FREE CONFERENCE COMMITTEE ON SENATE BILL 223

Call to Order: By **CHAIRMAN TOM KEATING**, on April 12,. 1995, at 3:20 PM.

ROLL CALL

Members Present:
Sen. Thomas F. Keating (R)
Sen. Mignon Waterman (D)
Rep. Royal C. Johnson (R)
Rep. Loren L. Soft (R)
Rep. Joe Barnett (R)

Members Excused: Sen. Larry L. Baer (R)

Members Absent: None

Staff Present: Karolyn Simpson, Committee Secretary

Discussion: SB 223

{Tape: 1; Side: 1; Comments: Some comments unintelligible due to room noise and mumbling .}

SENATOR KEATING said this is a Free Conference Committee on SB 223.

REP. JOHNSON said the Conference Committee, at its last meeting, had decided to accept the amendments. He said **REP. COBB** has some serious objections to the amendments, so he asked for comments from **REP. COBB.**

REP. COBB said he doesn't mind Managed Care, but doesn't want to expand the Medicaid eligibility numbers, especially when there is a possibility of Federal cuts in the Medicaid program. He thinks it's best not to expand Medicaid, because it will be an additional tax on the system. He said this year there may be a need to help 6,000 people, but by next Session there may be a waiting list of 10,000. He is not against Mental Health Managed Care, but does not want to expand the Medicaid eligibility.

SENATOR WATERMAN said **REP. COBB** doesn't want to expand Medicaid eligibility. She said the idea for this program was to take the State hospital Medicaid Mental Health Program, the Community Mental Health Program, the MRM (Managed Resources of Montana)

Program and roll them all together. They all have different eligibility levels, but people are now being served to 200% of poverty in community programs. She asked **REP. COBB** if he wants to cut back on people being served or doesn't want to serve them with Medicaid dollars but it's OK to continue to serve them at 100% from the General Fund.

REP. COBB said yes. The General Fund is being used now and should continue being used as needed. Even under the MRM program the number of kids in the system are still not the number rejected. This is not a fully funded program. There is not enough money to go to 200% of poverty and asked if General Fund money can't be continued.

SENATOR KEATING summarized, saying **REP. COBB's** concern is in several areas. Expanding eligibility, meaning that 150% of poverty is what he is recommending as opposed to 200% of poverty. He asked **REP. COBB** if that was correct, and said his amendment was 150% of poverty.

REP. COBB said his amendment was for 100% of poverty, now it's at 40% of poverty.

SENATOR KEATING said people at 200% of poverty now are eligible for care under the rules, and this is not being changed. By **REP. COBB's** amendment it is not cutting eligibility.

REP. COBB said he is not including the Medicaid mandates that come with it. Under SB 223, once a person gets Medicaid, they get all the services. He said he doesn't want to take the Federal dollars because of the Balanced Budget Amendment.

SENATOR KEATING asked Dr. Blouke to respond to the point of eligibility and additional cost of Medicaid.

Peter Blouke said they are already paying for these clients with 100% General Fund. What they are suggesting is using 200% of poverty which would cover the vast majority of people who are already receiving services using the General Fund. These people would be brought into the Medicaid Managed Care Program and, instead of paying for those services with 100% State dollars, Medicaid funds would be used and then would only pay 30% of what is currently being paid. The eligibility issue is really a technical issue with the Medicaid program. It is only for mental health services, and going to the Medicaid Managed Care Program, those people would be moved to the most appropriate, least expensive services. Now 100% General Fund dollars are being used in many cases for the most expensive service.

SENATOR KEATING asked if the number of people to be cared for is being expanded by going Managed Care and using Medicaid dollars, or will it be the same number clients with a mixture of Federal and State dollars rather than General Fund.

Peter Blouke said there would be more clients, but it's not 200,000. The only people being talked about are those needing mental health services, not the physical health services. Partially there would be additional people, but he didn't think there would be that many who are not currently receiving services. For this group between the currently Medicaid eligible and the expanded category, the Managed Care Company will be paid a finite number of dollars to provide services no matter how many people.

SENATOR KEATING asked if people currently on SSI for mental health care would be included in this group.

Peter Blouke said if they are already on SSI, they are automatically on Medicaid and are already in this group.

SENATOR KEATING said with the Managed Care Program, they are already qualified, but they could earn more money under this program, above and beyond SSI limits.

Peter Blouke said if eligibility is moved to 200%, they can retain more of their earnings than they can under the SSI. For AFDC, which is a large portion of the very vulnerable population, the poverty level is 42-48% of poverty. This is a very vulnerable group and they need some assistance to keep from losing their jobs, or dropping into the full welfare system.

SENATOR KEATING asked if under the **COBB** amendment they would be dropped out.

Peter Blouke said under the **COBB** amendment, they would maintain their eligibility at the present level, with pregnant women and children to 133%, and children between the ages of 1-12.

SENATOR KEATING asked if these people are currently being served, and if the eligibility level is raised to 200%, will they still be served.

Peter Blouke said they would be, but they would be served more efficiently. Because the Legislature reduced the Governor's executive budget for MRM by $4 million, this reinforces the reason to go to Managed Care where available resources can be more efficiently used.

Kathy McGowan said Crisis Services in the community is not funded so SRS is squeezing those served by General Fund dollars, and the available money needs to be more efficiently used. She said because a new, but smaller, State hospital is being built and community services are not being funded at a higher level, the continued use of General Fund dollars will serve some people, but those on the waiting list will not be served.

SENATOR WATERMAN said if the 200% eligibility level is used, it would eliminate the multiple eligibility criteria and turn over

the eligibility determination to the Managed Care Company, but with the present system, there are several agencies determining eligibility resulting in increased bureaucracy.

SENATOR KEATING said it would be a narrowing of area of determining eligibility at the State level.

SENATOR WATERMAN said it would decrease some of the administrative costs for determining eligibility, which would be contracted out.

Peter Blouke said that is correct.

Nancy Ellery said the contractor will only be determining eligibility for the expanded population, the new group up to 200% of poverty, and County offices will continue determining eligibility for the present population.

REP. BARNHART asked how much expansion there will be and wondered if there were numbers in mind for this expansion.

Peter Blouke said the Managed Care portion is not an expansion, but would use money already in the system for MRM and for the State hospital within the regular, but reduced, SRS budget, which they reduced by $2.1 million in anticipation of this program. He said without the Managed Care program, SRS would have to ask for more money.

REP. BARNHART said **REP. COBB** he is concerned about expanding Medicaid eligibility resulting in additional clients, and she asked how many.

REP. JOHNSON said approximately 11,742 people.

SENATOR WATERMAN said there is a difference who is eligible for Medicaid and who is now eligible for mental health services, because people are getting these services in mental health clinics and they may be on waiting lists, but they are being served very efficiently.

REP. JOHNSON asked **REP. COBB** to respond to what has been said.

REP. COBB said he is concerned that expanding the number of people eligible for Medicaid, it drives costs up, maybe not in the first or second years, but they will go up. He is not against Managed Care because Managed Care is supposed to be up and running, but doesn't want to increase the numbers of people eligible for the program. He said once services are provided, and Managed Care would probably be cheaper, but is concerned about starting a new program and the expansion eligibility. He said if the program is not totally funded, how can eligibility be raised to 200%.

REP. JOHNSON asked **REP. COBB** if the current delivery system is OK.

REP. COBB said it is not.

REP. JOHNSON asked, then why not try a new system to possibly add 11-12,000 more people on the basis that there will be more money to add those people by using this particular method. He said he is not happy with the present system and thinks this new system should be tried, and MRM may or may not be a part of this situation, once they go to Managed Care.

REP. COBB said the testimony he had heard from the Directors previously, MRM is going away. He said 11 or 12,000 additional people will come into the system when eligibility is expanded. He is concerned what is going to happen if this big program is created and the Federal Government cuts back, and what the situation will be 2 years from now if cuts have to be made, and where the cuts will be made. He said when the Federal Government increased eligibility, the numbers went up-up-up.

REP. JOHNSON said people working in the system say many more people will be added by using the 132% than by confining it to mental health at 200%, and 90% of those people under 200% of poverty are currently being served. He said he doesn't know what the Federal Government is going to do and the State must be careful when depending on Federal because it may or may not be there. With Managed Care, MRM is not going away but it won't stand as an independent agency, and may be lumped into one or more of the other care providers who bid for the Managed Care system.

REP. COBB said he is not against Managed Care, but when eligibility is increased, there will be more people to be served. He said he wants to look at long term budget and look at the big picture, and not just SRS.

REP. SOFT asked, if the 200% poverty level is not used, there won't be any Managed Care companies interested because it will require them to go to an HMO status in the State, and they don't want to do that, and it will not be possible to attract an outside Managed Care entity.

Peter Blouke said that was correct and would essentially kill Managed Care.

REP. COBB asked, when HB 33 was passed, if anybody bid on that.

Peter Blouke said they haven't heard specifically because they haven't asked the companies if they would come in if they had to meet all the requirements of an HMO, but corporations in other states who are managing similar programs, don't meet the HMO's requirements, which is why that provision was included in SB 223.

SENATOR WATERMAN said MRM providers, the clients, and Mental Health Clinics are all supportive of this proposal. She said, in the past, **REP. COBB** advocated expanding Medicaid for kids because it was cost effective and would save money in the long run, and that is what is being said about this program. He may be right that the 1997 Legislature will have to cut services if the Federal Government has cut back on funding or State resources are not available. By then, there will be an understanding of a whole system and how it can be reduced, but she knows services will have to be cut in 1997 if the present fractured system continues.

REP. COBB asked it is being suggested to vote in the Conference Committee, then let it go back on the Floor again.

REP. BARNHART asked **REP. COBB** if it is 200% or nothing, and no compromise.

Peter Blouke said he is not suggesting 200% or nothing, but 200% is the most efficient way to do it. It can be reduced, but the problem with decreasing it, the State will still have to provide those services to those people now in the system.

Kathy McGowan said, referring to the 200% poverty issue, if the Federal Government do all the rash things some people predict, are they even likely to grant the waivers.

Peter Blouke said he thinks they would grant the waivers because they are willing to give flexibility to the States and they are talking about block grants to the States. He said this is just a sample of what will have to be done in the Medicaid program and would have to make some very serious adjustments. In the long term, this program will be a savings.

SENATOR KEATING said he has listened to the explanation of cutting Medicaid, they are really talking about cutting the Federal bureaucracy and giving block grants to States, out of the appropriated funds, to cut the Medicaid expense by cutting administrative costs at the Federal level. He said jobs may be cut in Washington, D.C., he doesn't think there would be that much less in Medicaid funding.

Kathy McGowan asked if 200% of poverty were granted, then Federal Government cut Medicaid, then is the State stuck with the 200% and have pick up costs.

Peter Blouke said during any period of the waiver process, if circumstances change or it is seen this is not working, the State can change it.

SENATOR KEATING said the State would not be locked into a Managed Care contract to the State's disadvantage. He said they are dealing with mental health care, and looking at other Medicaid programs, there always have been clientele because the symptoms are being addressed and never getting to the problems and causes.

Through MRM, they are now at the point of interdicting at a very early level to provide those minimum level services resulting in a healing and people's lives can be changed, and be taken off the rolls. He said, under this program, the number of clientele will decrease, or stay the same, but probably not an increasing number of clientele. This program will effectively solve the problem.

Motion: REP. BARNHART moved to go down to 185% of poverty level.

Motion: SENATOR WATERMAN made a substitute motion to restore 200% of poverty level to SB 223.

REP. JOHNSON asked how the Senate voted on the amendments that are being discussed and whether the Senate accepted those amendments. He said **REP. COBB** was the 1993 Session leader in health care and asked if he would support any change other than zero to 200%.

REP. COBB said he would compromise at 100% poverty for adults and children, or 133% just for kids, but for mental health care only.

SENATOR KEATING said when this was started, the principal objection was going to Medicaid but instead stay with General Fund dollars and not go to Medicaid. Now, the desire is to compromise at a certain level, but that means it will be Medicaid. He asked **REP. COBB** if he had moved away from his objection to using Medicaid.

REP. COBB said he would rather not do it, but was asked a question about his willingness to compromise, and he is trying to do so. He said he doesn't want to expand it.

SENATOR WATERMAN said she can't support going down to the 100% poverty level because many people will be cut who are presently being served.

REP. JOHNSON asked **SENATOR WATERMAN** if her motion was to stay at 200%.

SENATOR KEATING said the motion is to reject the **COBB** amendment and both Houses go with 200% of poverty.

REP. JOHNSON said **REP. COBB** doesn't have an amendment, but doesn't want to go with this amendment.

SENATOR KEATING said **REP. COBB's** motion deleted the 200% level from the bill. The motion agreed to at the Conference Committee was the House would recede from the **COBB** amendment and restore the bill to 200%, and that was rejected by the House and accepted by the Senate. He said the amendment is to restore the 200% of poverty level, rejecting the **COBB** amendment, putting the bill back to the level at which it entered the House.

Vote: **The motion to restore the 200% of poverty level to SB 223, and rejecting the COBB amendment CARRIED UNANIMOUSLY.**

REP. BARNHART asked what will happen if it again fails in the House.

SENATOR KEATING said if it fails on the floor tonight, then they will have to have another Conference Committee meeting. He said the motion is to restore SB 223 to 200% of poverty, which means, procedurally, they go back their respective Houses, and the motion there will be that the House will accept the Committee report, receding from the **COBB** amendment.

REP. JOHNSON said he the House already receded from that, but now they are starting at ground zero where the 200% of poverty is added in.

SENATOR KEATING said page 11 of the bill has to go to back to the way it was.

REP. JOHNSON said that is right, by **REP. COBB's** amendment not to concur.

SENATOR KEATING asked **REP. JOHNSON** if he was going back and ask the House to Concur with the first recommendation of the first Conference Committee.

REP. JOHNSON said that was correct.

ROLL CALL

FREE CONFERENCE or CONFERENCE COMMITTEE

ON BILL NO. SB 223

DATE 4/12/95

NAME	PRESENT	ABSENT	EXCUSED
Senator Keating	✓		
Senator Baer			
Senator Waterman	✓		
Rep. R Johnson	✓		
Rep. Soft	✓		
Rep Barnhart	✓		

CCROLL.F18

Free Conference Committee
on SB 223
Report No. 1, April 12, 1995

Mr. President and Mr. Speaker:

We, your Free Conference Committee on SB 223, met and considered:

SB 223 in its entirety

We recommend that SB 223 (reference copy as amended - salmon) be amended as follows:

1. Page 11, line 24.
Following: "~~department.~~"
Insert: "The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department."

And that this Free Conference Committee report be adopted.

For the Senate:

Keating
Chair

Baer

Waterman

Amd. Coord.

Sec. of Senate

For the House:

R. Johnson
Chair

Soft

Barnhart

ADOPT

REJECT

841716CC.SPV

SENATE BILL NO. 223

INTRODUCED BY KEATING, WATERMAN, SIMON, BECK, SWYSGOOD, BURNETT, T. NELSON

BY REQUEST OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO MANAGED CARE MENTAL HEALTH SERVICES PROVIDED UNDER THE MONTANA MEDICAID PROGRAM; PROVIDING FOR THE AWARD, MANAGEMENT, PAYMENT, AND AVAILABILITY OF THOSE SERVICES; PROVIDING FOR EXCEPTIONS TO LAWS GOVERNING INSURANCE CONTRACTS AND HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING FOR ELIGIBILITY DETERMINATIONS AND LIMITATIONS; REVISING THE PROCEDURES FOR VOLUNTARY ADMISSION TO THE MONTANA STATE HOSPITAL; AMENDING SECTIONS 33-1-102, 33-31-202, 33-31-301, 53-1-401, 53-1-402, 53-1-413, 53-2-603, 53-6-131, 53-6-132, 53-21-111, AND 53-21-206, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-102, MCA, is amended to read:

"**33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs.** (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of those organizations are authorized by chapter 31.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, parts 21 and 23, and related sections.

REFERENCE BILL: INCLUDES FREE CONFERENCE COMMITTEE REPORT DATED 4-12-95

5d

(6) This code does not apply to the functions performed by a managed care contractor providing mental health services under the Montana medicaid program as established in Title 53, chapter 6.

~~(6)~~(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

~~(7)~~(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

~~(8)~~(9) (a) This code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) This code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program."

Section 2. Section 33-31-202, MCA, is amended to read:

"**33-31-202. Issuance of certificate of authority.** (1) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after ~~he receives~~ receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may ~~in his discretion~~ consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection ~~therewith~~ with the services;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with 33-31-216; and

(vi) any additional information ~~as~~ that the commissioner may reasonably require.

(d) The enrollees ~~will~~ must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may ~~in his discretion~~ deny a certificate of authority only if ~~he complies with~~ the requirements of 33-31-404 are complied with."

Section 3. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence

of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area~~;~~.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and

nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(f) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is ~~hereby~~ amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, ~~his~~ dependents, or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of ~~his~~ membership in the class or classes eligible for coverage under the policy or because ~~his~~ the employer discontinues ~~his~~ the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months

preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1)

through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, ~~he~~ the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for ~~his~~ the disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receipt of a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any relevant information ~~he considers~~ considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 4. Section 53-1-401, MCA, is amended to read:

"**53-1-401. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "All-inclusive rate" means a fixed charge that is computed on a daily basis or on the basis of another time period for inpatients, that is computed on a per visit basis for outpatients, and that is applicable uniformly to each patient without regard to the extent of the services required by the patient and without regard to a distinction between physician services and hospital services.

~~(1)~~ (2) "Ancillary charge" means the expense of providing identifiable, direct, resident services, including but not limited to:

(a) physicians' services;

(b) x-ray and laboratory services;

(c) dental services;

(d) speech-language pathology and audiology services;

(e) occupational and physical therapy;

(f) medical supplies;

(g) prescribed drugs; and

(h) specialized medical equipment.

~~(2)~~ (3) "Care" means the care, treatment, support, maintenance, and other services rendered by the department to a resident.

~~(3)~~ (4) "Department" means the department of corrections and human services provided for in Title 2, chapter 15, part 23.

~~(4)~~ (5) "Financially responsible person" means a spouse of a resident, the natural or adoptive

parents of a resident under 18 years of age, or a guardian or conservator to the extent of the guardian's or conservator's responsibility for the financial affairs of the person who is a resident under applicable Montana law establishing the duties and limitations of guardianships or conservatorships.

~~(5)~~ (6) "Full-time equivalent resident load" means the total daily resident count for the fiscal year divided by the number of days in the year.

~~(6)~~ (7) "Long-term resident" means a resident in an institution listed in 53-1-402 for a continuous period in excess of 120 days. ~~No~~ The absence of a resident from the institution due to a temporary or trial visit may not be counted as interrupting the accrual of the 120 days required to attain the status of a long-term resident.

~~(7)~~ (8) "Per diem" means the gross daily budgeted cost of operating an institution or an individual unit of an institution (including certain contracted medical services, depreciation, and associated department costs but excluding the cost of educational programs, federal grants, ancillary charges, and costs not directly identified with patient care) divided by the full-time equivalent resident load.

~~(8)~~ (9) "Resident" means any person who is receiving care from or who is a resident of an institution listed in 53-1-402.

~~(9)~~ (10) "Third-party resource" means but is not limited to applicable medicare, medicaid, and personal health care benefits."

Section 5. Section 53-1-402, MCA, is amended to read:

"**53-1-402. Residents subject to per diem and ancillary charges.** (1) The department shall assess and collect per diem and ancillary charges for the care of residents in the following institutions:

(a) Montana state hospital;

(b) Montana developmental center;

(c) Montana veterans' home;

(d) eastern Montana veterans' home;

(e) Montana center for the aged;

(f) Eastmont human services center.

(2) This section does not apply to the eastern Montana veterans' home if the department contracts with a private vendor to operate the facility as provided for in 10-2-416.

(3) This section does not apply to residents of the Montana state hospital or to the Montana center

for the aged to the extent that either of these institutions assesses and collects charges through an all-inclusive rate rather than per diem and ancillary charges."

Section 6. Section 53-1-413, MCA, is amended to read:

"**53-1-413. Deposit of payments.** (1) Except as provided in 90-7-220 and subsection (2) of this section, the department shall deposit payments of per diem and ancillary charges in the state treasury to the credit of the general fund.

(2) Payments from the Montana veterans' home ~~shall~~ must be deposited in the federal special revenue fund for the benefit of the home, and payments from the Montana state hospital alcohol program ~~shall~~ must be deposited to an alcohol state special revenue account.

(3) Payments from a managed care contractor, provided for in 53-6-116, for services provided by the Montana state hospital and the Montana center for the aged must be deposited in the state special revenue fund, subject to appropriation by the legislature for the benefit of those institutions."

Section 7. Section 53-2-603, MCA, is amended to read:

"**53-2-603. Award of public assistance determined after investigation.** (1) Upon completion of an investigation, the county board shall determine whether the applicant is eligible for public assistance under the provisions of this title, the type and amount of public assistance ~~he~~ the applicant ~~shall~~ must receive, and the date upon which ~~such~~ the public assistance ~~shall~~ must begin. This subsection does not apply to any form of public assistance managed by a managed care contractor, as provided in 53-6-116, when a determination of eligibility is made by the managed care contractor.

(2) The department, if necessary to conform with the United States Social Security Act, may issue rules to the county welfare departments requiring the use of the declaration method, in ~~such~~ a form ~~as~~ that the department may prescribe, for the purpose of determining eligibility, regardless of any other investigative provisions under this title, and for all types of assistance. These rules may include any additional investigations the department may require."

Section 8. Section 53-6-131, MCA, is amended to read:

"**53-6-131. Eligibility requirements.** (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of social and rehabilitation services, in

its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. 1381, et seq.) or aid to families with dependent children under Title IV of the federal Social Security Act (42 U.S.C. 601, et seq.).

(b) The person would be eligible for assistance under a program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under one of the programs in subsection (1)(a).

(d) The person is under 19 years of age and meets the conditions of eligibility in the state plan for aid to families with dependent children, other than with respect to school attendance.

(e) The person is under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a hard-to-place child.

(f) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(e) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the department the amount by which the person's income exceeds the medically needy income level specified for federally aided categories of assistance; and

(B) has resources that are within the resource standards of the federal supplemental security income program.

(g) The person is a qualified pregnant woman or child as defined in 42 U.S.C. 1396d(n).

(2) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program.

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the

department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

(a) has income that does not exceed income standards as may be required by the federal Social Security Act; and

(b) has resources that do not exceed standards the department determines reasonable for purposes of the program.

(4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

(5) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.

(6) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.

(7) A person described in subsection (6) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

~~(8) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households with family income that does not exceed 200% of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department.~~ THE DEPARTMENT MAY ESTABLISH RESOURCE AND INCOME STANDARDS OF ELIGIBILITY FOR MENTAL HEALTH SERVICES THAT ARE MORE LIBERAL THAN THE RESOURCE AND INCOME STANDARDS OF ELIGIBILITY FOR PHYSICAL HEALTH SERVICES. THE STANDARDS FOR ELIGIBILITY FOR MENTAL HEALTH SERVICES MAY PROVIDE FOR ELIGIBILITY FOR HOUSEHOLDS WITH FAMILY INCOME THAT DOES NOT EXCEED 200% OF THE FEDERAL POVERTY THRESHOLD OR THAT DOES NOT EXCEED A LESSER AMOUNT DETERMINED IN THE DISCRETION OF THE DEPARTMENT. The department may by rule specify under what circumstances

deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees to be charged recipients for services. The fees may vary according to family income."

Section 9. Section 53-6-132, MCA, is amended to read:

"**53-6-132. Application for assistance -- exception.** (1) ~~Application~~ Except as provided in subsection (2), application for assistance under this part ~~shall~~ must be made to the office of the county department in the county in which the person is residing. The application ~~shall~~ must be presented in the manner and on the form prescribed by the department of social and rehabilitation services. All individuals wishing to apply ~~shall~~ have the opportunity to do so.

(2) Notwithstanding the provisions of subsection (1), the department may designate an entity other than the county department to determine eligibility for medicaid managed care services."

Section 10. Section 53-21-111, MCA, is amended to read:

"**53-21-111. Voluntary admission.** (1) Nothing in this part may be construed ~~in any way as limiting~~ to limit the right of any person to make voluntary application for admission at any time to any mental health facility or professional person. An application for admission to a mental health facility ~~shall~~ must be in writing on a form prescribed by the facility and approved by the department. ~~It~~ An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily ~~admitting himself~~ admitted. A statement of the rights of the person voluntarily applying for admission, as set out in this part, including the right to release, ~~shall~~ must be furnished to the patient within 12 hours.

(2) Any applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person ~~must~~ shall then obtain confirmation from ~~a community mental health center~~ the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from ~~a community mental health center~~ the department or the department's designee as required in this section.

(3) An application for voluntary admission ~~shall~~ must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past ~~his~~ the applicant's written

request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility ~~must~~ shall notify all applicants of ~~such~~ the rules and post ~~such~~ the rules as provided in 53-21-168.

(4) Any person voluntarily entering or remaining in any mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility."

Section 11. Section 53-21-206, MCA, is amended to read:

"**53-21-206. Availability of services.** (1) The services of the department and of the incorporated regional mental health centers are available without discrimination on the basis of race, color, creed, religion, or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964.

(2) Services available to individuals unable to pay for the services may be limited by the department based upon availability of funding."

-END-